

# MENTAL HYGIENE

VOL. XXXIII

OCTOBER, 1949

NO. 4

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Mental Hygiene aims to bring dependable information to every one whose interest or whose health may be affected by mental problems. Vectors of authority present original investigations and reviews of scientific research; scholarly studies in psychiatric and psychological work to the general public are published; reports of surveys, special investigations, and new methods of prevention or treatment in the broad field of mental hygiene and psychopathology are presented and discussed in an accessible way as possible. It is our aim to make mental hygiene intelligible to all, including students, physicians, lawyers, educators, clergymen, public health and students of social sciences and the magazines of special interest.

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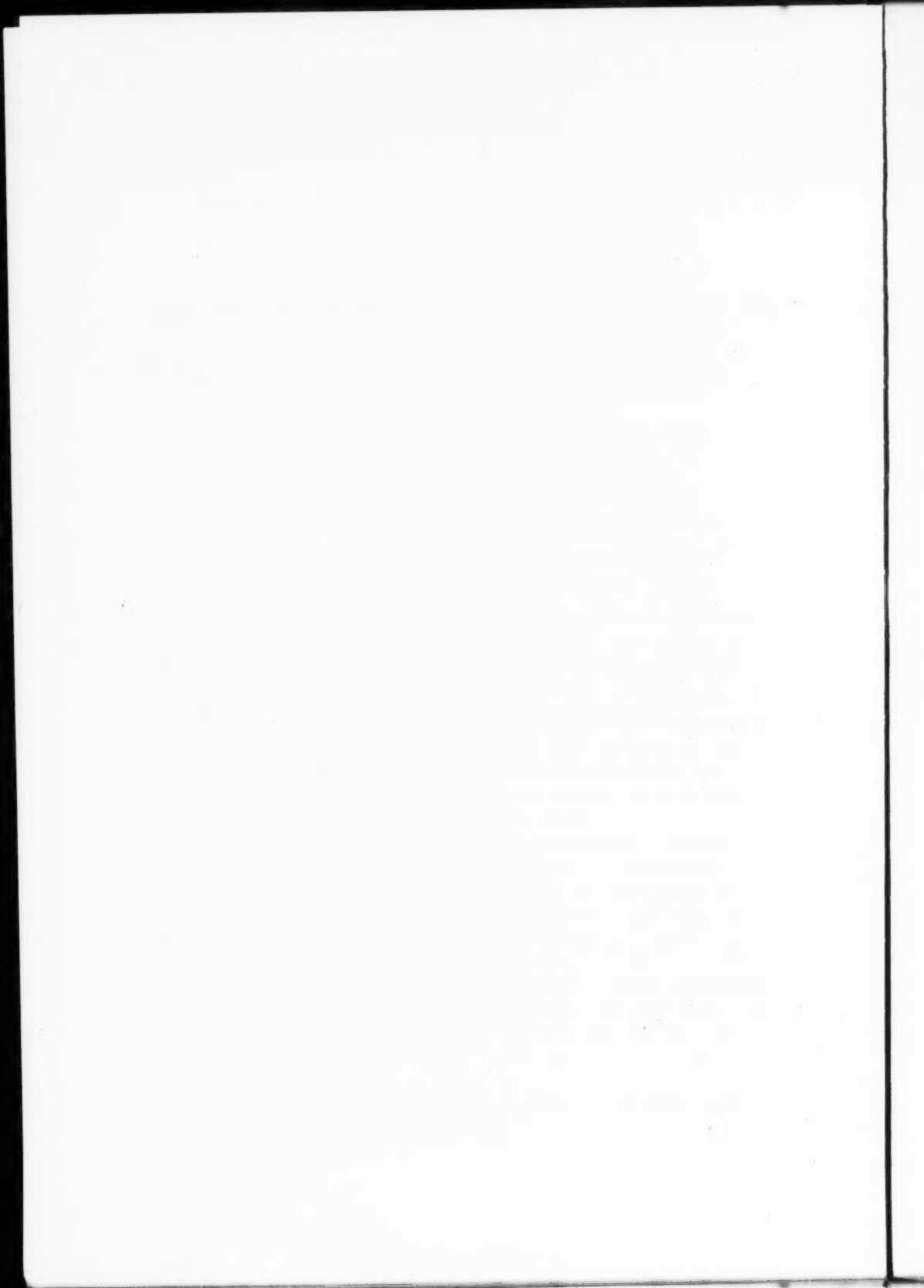
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# MENTAL HYGIENE

VOL. XXXIII

OCTOBER, 1949

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## A CONTRIBUTION TOWARD THE STUDY OF CHARACTER BUILDING IN CHILDREN \*

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IN the summer of 1931, it occurred to me in an idle hour that by the year 2000 our descendants will know a great deal more about human heredity than we know to-day. Obviously, when that knowledge comes, people will have a greater interest in the character traits of their ancestors than in mere names and dates and places of birth, marriage, and death. Having four children who might, in their maturer years, be thus interested in their forebears' traits, or have children who would be interested, I wrote out detailed descriptions of the physical characteristics and character traits of my mother and father and their seven children, of my wife's mother and father and their five children. These records, with appropriate photographs, I hope to pass on to my children against the day when to them or their children such accounts will almost certainly be interesting and perhaps of real value.

I venture to mention this bit of personal experience because, as it turned out, this simple procedure furnished us with extremely suggestive material for child study. It was not difficult to do, but if there be such a thing as slow and growing surprise, then that was what I have experienced as I have watched my children develop. So many of their

\* Presented at the Annual Conference of the Child Study Association of America, New York City, March 7, 1949.

unfolding distinctive personality traits were already somewhere in these records of parents, grandparents, aunts, or uncles. But these reappearing traits were in new arrangements, and these new combinations were so refreshingly, so astonishingly different one from another—sometimes a thread that had been nowhere observed before; often threads seen before, but now in a pattern that, as a pattern, was startlingly unique. It reminded me of the impressions one would receive from laying an empty picture frame on four different parts of a Scotch tartan—the threads so often similar, but the effect or pattern so singularly distinctive. Here was, in effect, a method of child study that is within the range of all interested in that field.

If the first result of this experience was that it gave me a new concept of personality and of the uniqueness of the individual child, and the absolute and independent nature of his character, the second result was a sort of assurance that I was here dealing with phenomena that might be constant and dependable. Wise as it usually is to realize that children pass through phases, I took some satisfaction in admitting to myself that possibly there are traits that are not transitory and ephemeral, but lasting and describable. When one of the children began to show an interest in words that I had already recorded his grandfather as having displayed at the age of six and having continued to enjoy for seventy years, I felt something of increased confidence that this trait was really *there*, to be developed and released. To date, at least, it continues, constant and, I think, dependable.

Besides greatly increasing the wonder and delight of watching recognizable elements unfold in perfectly new arrangements, and thus accentuating the novelty that each human being possesses even before experience begins to reveal it fully, studying children by describing their antecedents seems to me to increase our available methods of child study. Human heredity is, at the very best, in hardly more than a very early stage of its growth as a science. It is still at a stage when comprehensive observation and careful records are perfectly justifiable scientifically. We can record, collect, and compare such observations and still be free from the charge of being inconsequential or scatter-

brained. We can be amateurs without being dilettantes. We can record without coming to conclusions. Indeed, much of the discredit that laymen attach to heredity, classically contrasted with environment, comes from the reckless and fatalistic haste with which far-reaching conclusions have been drawn from inaccurate and inadequate observations.

But perhaps the worst mistake regarding heredity derives from the widespread ignorance of one of its simplest laws. This is the so-called law of filial regression. In effect, this so-called "law of nature" describes a uniform tendency for an hereditary trait that is strong or strongly marked in a parent to be less strongly marked in the offspring. This is easy to understand if you remember that since the trait is exceptionally strong in one parent, it is likely to be less marked in the other parent and, therefore, it will be in a sense diluted in the usual process of hereditary transmission. In this fact there is hope if it be an unpleasant trait and a check on too great expectations if the trait is pleasant. In some senses nature protects her children by avoiding extremes. A young man who stands six feet three in his stocking feet who marries a girl of average or less than average height in whose family none of the men have been taller than, say, five feet eight, can look forward to children whose height will regress or go back from his own excessive stature. They won't be as tall as their father. Hence the term filial (concerned with the children) regression (return toward the average). Of course, if both parents come of tall stock, even if one or both have been stunted by illness or inadequate nutrition, then the children may be taller than either parent—a result commonly observable these days from the improved hygiene and wiser nutrition of modern child care.

However, the interrelationship of heredity and environment appears to be just subtle and complicated enough to escape the comprehension of people who cannot understand that a result may come from a *combination* of causes and not one cause alone. A good dinner is the product of good foodstuffs to start with and good cooking. A fine cook, like an excellent environment, can bring out the best there is in the groceries she starts with, and a poor cook can spoil the potentialities of excellent raw material. Therein lies the

value of a good cook—and good groceries. Heredity deals with potentialities, environment with bringing out the potentialities. How stupid to insist on ignoring one or the other! And how regrettable to assume that when a child has two parents and is also the result of both environment and a mixed heredity, he will exactly equal one or the other of his parents! Yet the importance of heredity is ignored or belittled by minds incapable of taking more than one factor into account.

Indeed, I find some embarrassment in the fact that if I am to correct what seems to me to be an excessive weight attached nowadays to environment, I must exaggerate the rôle of heredity in order to present a more evenly balanced view of reality. It seems necessary to be extreme in the service of moderation, and absurd in order to arrive at reasonableness. And the truth is all the more difficult to find because all the potentialities of heredity are settled before the long tasks of environment can begin. Playing good bridge begins *after* the cards have been dealt. But at how many bridge tables this afternoon will bridge players explain their successes and their failures in terms of the cards they held! Even this comparison fails in one point, for it suggests that we all draw our hereditary traits always from a single uniform deck of human heredity which is the same for every one of us. We don't. We draw our heredity from a mixture of two decks, as it were, and neither of these decks entirely visible or verifiable now or in the past. And with far more genes in each deck than in the relatively simple little deck of fifty-two cards—far more.

If we don't provide a good environment for a child, his hereditary possibilities will not become apparent, but that is no good scientific reason for turning our attention entirely away from heredity if we seek real understanding. That would be a kind of intellectual cowardice which you can practice if you insist, like a neurotic, in ignoring the facts. But if you do so insist, then there are some penalties for such deliberate ignorance and disregard of the realities. What are some of the penalties?

If you believe that a child is exclusively the result of nothing but his environment, then how are you going to explain his conduct or character if it is not at all agreeable?

There are plenty of parents who feel perfectly fantastic degrees of guilt at the outcome of what they regard as the product of nothing but their own mismanagement. The child is thus doomed to being brought up in the gloomy atmosphere of parental guilt and defeat, from which he can escape, if at all, by pitying himself as the irresponsible product of his own parents' monumental ineptitude. His failures and his successes are explained for him in advance, and forever, as being not his, but his parents'. And the general attitude of guilt, defeatism, and over-all failure spreads out like a pall of smoke to hang over the whole idea of raising a family—and thus pollutes an atmosphere which could have been sunny and honest and humble in the face of the whole truth.

Then there are parents who take out their feelings of frustration, not in a perpetual cloud of self-accusation and Calvinistic guilt, but in embittered resentment and hostility to the child whose failure to respond to a "perfect" environment is felt by the parents as a wilful frustration of their dearest hopes and fondest efforts. What an atmosphere to grow up in! What a price to pay for insisting that environment is everything! Environment is not everything; it is merely the factor in child-raising on which we can sensibly spend our best intelligence and our eager efforts in the certain conviction that it will affect, without ever being the only thing to affect, the end result. It is not necessary to succeed in order to work hard. Mature people know that—or perhaps that is what maturity means. Complete maturity has something of the heroic.

Another common consequence of implicit and exclusive reliance on environment is the conviction that you can manufacture human beings according to specifications if you can only control their environment. According to this assumption, we can neatly contrive to make our children stand, not on their own feet, but on our ambitious shoulders and thus reach unimagined heights while the audience gasps at them and applauds us. I suppose this explains the unending appeal of those acrobatic families in the circus who pile themselves up in taut and agonizing pyramids with little Célestine balancing for a brief moment at the very apex of a groaning family, and, with a forced smile, waving a

precarious salute to the gaping yokels in the audience. Nature fortunately comes to the aid of Célestine and all the child prodigies. They grow up. They tire of capping the tense family pyramid and come to prefer doing their own tricks in their own right, standing on their own feet. They also tire of catching hell from zealous parents for not posing forever on their mother's and father's ambitious shoulders. They even feel they have their own lives to live. Were you ever a Célestine? Or a tense parent?

One more mistake of those who insist that environment is everything: they overload their children with stimuli, which they call "advantages." They crowd these children with an impatient succession of sensations and demands. They cheat their children of the very thing they are proudest of having done themselves—succeeding in spite of not having all the advantages. They do not seem to know that it takes time for a child to respond fully and completely to a powerful impression. They misinterpret that beautiful stillness of children when vivid impressions are being organized into happy memories or creative responses—they misinterpret this stillness, thinking that nothing has registered and so another stimulus must be forced onto the child's mind that they foolishly think is unoccupied or unimpressed because it is quiet.

In my opinion the fact that so many creative men and women tell us that in childhood they had much illness or loneliness or lots of time to swing on the gate is more significant than we realize. Illness and freedom from overstimulation give a child time to absorb his impressions, to integrate and organize them and finally to create from his whole being a response. Unless we give children time to organize their sensations, their impressions—in short, time to react to their environment—we shall produce even more of what we see enough of already—a profusion of moralists plagued with more than enough rebels, and all too few men or women of solid, steady virtue and stability.

Virtue in the Greek sense of that word means consistency of conduct with inner conviction. How can you expect a child to develop consistency of conduct with conviction if you so crowd him with stimuli that he never forms the habit of responding with his whole being to what he has felt?

He cannot react. He has not time to form convictions. He is not given time before the next load of impressions or obligations is pressed upon him. No—under an unremitting pressure of stimuli, even if these stimuli be scheduled and well chosen, the child will either become rebellious in a deep and pervasive fashion, or else a hasty and superficial conformist incapable of assimilating so many impressions or forming any original or selective opinions. He has not time to organize his responses. Without his own convictions he will, as the only possible alternative, be forced to rely upon the conventions and mores of his time and place in society.

In exaggerating the importance of environment, which is the sum total of stimuli, we often forget to allow time for the formation of character, which involves the organization and the expression of response to stimuli. By crowding the input, we spoil the output. By overloading our children with strong impressions in quick succession, we deprive them of originality and self-reliance. That is the great loss of putting such hectic emphasis on environment merely because we falsely think we can do nothing about heredity. The best bridge player plays his hand, even if it is a poor hand, with skill and equanimity—and when it is not bridge, but life, with what I can only think of as rare and beautiful resignation and nobility.

If you find the distinction I have suggested between morality and virtue strange or incomprehensible, let me repeat that whereas following the mores about us may be moral, conducting our lives consistently with our convictions is virtuous. Obviously if we have no inner convictions, there is no chance to be virtuous. But that doesn't leave us with the alternative of total depravity. Fortunately we can pattern our conduct on the mores of our day and generation, and at least escape bewildered ostracism. Indeed it is possible that the great value of morals is that they provide a guide line for great numbers of people who, having no convictions, cannot be virtuous.

Nonetheless, we may be wise to remember that within these definitions it is possible to be moral without being virtuous, or virtuous without being moral. If you are driving on a speedway in a car with a front tire you are convinced may blow out any time, you will be virtuous if you

don't go above thirty miles an hour, for your conduct will be consistent with your conviction. But all the other cars will honk at you for not following their mores and their pace of fifty-five to sixty. Or you can be moral and hit sixty—but you will not, in so doing, be virtuous. There often is some measure of loneliness and what is called “maladjustment” in being virtuous, along with vivid interest and deep satisfaction.

Indeed, if I had been following the mores of many people in the field of child study, I would not be making a case for the importance of heredity. But I cannot escape the conviction that in the face of all the evidence of the importance of heredity in the plant and animal world, we have been paying ridiculously little attention to its rôle in human life. A dependable knowledge of human heredity will require long and careful study to acquire. There are all sorts and conditions of men; divers heredities and environments. We are now in an early stage in which observing and recording the appearance and distribution of human traits in successive generations are appropriate, reasonable, and useful forms of study. One-sided emphasis upon nothing but environment has evident disadvantages, not because environment is unimportant, but because, like a hand without a thumb, it is incomplete for the purpose of grasping realities.

THE COMMUNITY AND THE  
AGGRESSIVE CHILD  
THE EXPRESSION OF THE AGGRESSIVE-  
DESTRUCTIVE IMPULSES IN  
JUVENILE-DELINQUENT  
ACTS \*

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THE problem of the aggressive child in the community brings all of us face to face with the much larger and more inclusive problem of juvenile delinquency. It is, I think, in a consideration of this more inclusive community problem that the origins and significance of aggressive acts in childhood can be brought out most clearly.

First of all, I wish to discuss the relationship of the juvenile-criminal *act*, particularly of an aggressive nature, to other acts of children called either (1) normal or (2) neurotic. And, secondly—contrary to the usual procedure of telling what psychiatry and medicine and sociology have contributed to the solution of this very vexing problem—I wish to point up and emphasize that the study of the delinquent act and of the delinquent youth can contribute to our knowledge of normal child behavior and of the child's stages and phases of development.

If the study of the neurotic—in the pure sense of the term—has contributed to our knowledge of human motivation, the study of delinquent behavior has contributed to an equal or greater degree—and bids fair, I believe, to make even more important contributions in the future. As to the distinctions between these two labels, "neurotic" and "delinquent," we are led immediately to our first problem—

\* This is the first of two papers on "The Community and the Aggressive Child." The second, *The Aggressive-Destructive Impulses in the Sex Offender*, will appear in the January, 1950, issue of MENTAL HYGIENE. A brief summarization of the two papers was presented at the International Congress on Mental Health, held in London, in August, 1948.

namely, the relationship of the juvenile-criminal act to normal and to neurotic behavior in childhood.

It has always seemed to me unfortunate that psychiatrists have attempted to differentiate between the motivations, purposes, and techniques of the so-called neurotic and the non-neurotic delinquent. Such a dichotomy, I am sure, is not in the least conducive to better understanding of the delinquent act—better, that is, from the point of view of the only worth-while object and purpose, that of enabling us to apply a better therapeutic approach or technique—and it has, I fear, in the second place, made us less appreciative of the lessons that the anatomy of the delinquent act can and will teach us about other neurotic syndromes and about normal behavior.

Hence, we probably should not approach the juvenile delinquent *diagnostically* with the question in mind: Is this a “neurotic” delinquent or is it a “non-neurotic” delinquent? Is this “neurotic” aggression or “non-neurotic” aggression? Of course, I know that all who work at close quarters with these problems in juvenile sessions, faced as they are with expanding case loads and inadequate psychiatric help, do their best to determine which cases must be—and should be—sent to the psychiatrist. All of us have urged this practical diagnostic approach to probation officers and judges for many years. But except in those cases in which the *material* lacks and needs are so outstandingly prominent and predominant that it is obvious that secondary gains and not primary (internal neurotic) gains are of paramount importance in causing the delinquency, I no longer think that such a distinction is fruitful.

This artificial distinction between the neurotic and the non-neurotic is, I think, less fruitful not only in the matter of our theoretical concepts of behavior, both the known and the to-be-known; it also continues to foster and to perpetuate in the minds of non-professionals that particularly reactionary and unrealistic point of view that a segment of our delinquents need diagnosis and individual treatment because they are neurotic, but that an even larger number do not need treatment—or, worse, need only discipline and punishment—because they are *not* neurotic.

What, then, are the possible theoretical bases for a concept

of juvenile delinquency as neurotic behavior upon which we can all agree, and that will eliminate for us at least this unsatisfactory differentiation? And in our discussion of this concept, the problem of childhood aggression as it relates to the community, in the most frequently encountered types of delinquency, will be seen in a clearer light. (I will take up later the question why we have been unable or unwilling to accept these concepts; and in that phase of our discussion I think you will see what I mean when I suggest that we note what the study of aggression in delinquent behavior has to contribute to our better understanding of motivations in normal behavior.)

I shall list some seven propositions or conceptions relative to neurotic behavior which are equally applicable to delinquent behavior, and in doing so I shall rely quite heavily upon the formulations of the psychoanalytic school in psychiatry.

1. All behavior—normal, neurotic, psychotic, or delinquent—is designed to fulfill some biological need of the organism.

2. In as much as the instantaneous and complete fulfillment of biological needs is impossible in most human communities, the individual in his development is subjected to blocks and frustrations to and delays in their fulfillment. Hence the behavioral result that is allowed expression is a compromise between the instinctual biological needs and the demands of communities of other human beings.

3. Thus there are only two criteria with which we measure human behavior—*i.e.*, these compromises—whether we look upon it biologically, socially, economically, psychiatrically, or spiritually: Is the behavior both (1) satisfying to the organism and (2) satisfactory to the community?

4. Now from the restricted area of our fields—*psychiatrically*—we label that behavior which is both satisfying and satisfactory as typical for society and culture, non-neurotic, non-psychotic, non-criminal. And behavior that is *either* unsatisfying or unsatisfactory, or *both*, we call either atypical, or neurotic, or psychotic, or criminal (in the case of an adult), or “delinquent” (if in a child below seventeen years of age). And, of course, our labels vary throughout the centuries.

5. And part and parcel of this concept is the added concept that such neurotic or delinquent behavior is *in some degree disabling*.

6. So much for a bit of behavior viewed cross-sectionally, or at the instant it is carried out as an isolated act or segment. But we have an equally important concept which we apply in our appraisal of behavior, and that is the concept inherent in our basic *genetic approach*. In other words, we must view behavior, too, in its *longitudinal* or developmental aspects, if it is to ever have *real* meaning for us, and we establish certain norms—age-span norms, if you will—within which span of, say, a few months at three or four years, or perhaps a span of a year or more between ages six and eight, we expect certain developmental steps to be taken, certain types of behavior to be manifested; *but after the age span in question is passed*, we expect these forms of behavior to be discarded and laid aside in favor of more satisfactory expressions of wants and needs.

If, however, these developmental phases, stages, segments, or components of our earlier life's development are *not* superseded, in the course of the educative process, by other and "better" compromises, but persist in their expression, we say that our child or adult is atypical, infantile, immature; and depending upon the specific nature of the persisting immature behavior, we say that he is neurotic or psychotic.

It is our thesis that this same genetic concept is applicable to all aggressive, delinquent, and criminal acts—and definitely should be applied if we are to have any uniform consistency in our own personal and workable theory of human behavior, or any self-assurance in our professional attack upon the problem of crime and the problem of the treatment of the delinquent child.

7. It follows then, finally, that the disabling feature or element of neurotic or delinquent behavior is the persistence into a later stage of development of a type of behavior—or manner of fulfilling a need, of attaining a pleasure—that was at an earlier stage "normal," but that should, under the community's demands, have been supplanted long since by a more acceptable expression of the need. Such "emotional rests" or "vestigial behavior" are characterized by

their irrationality and by the compulsive chronicity or periodicity in their expression.

Our present-day concepts of human behavior will allow us, I believe, to include the child's delinquent behavior—all delinquent behavior—within the framework of the neuroses. I do not believe we violate any of the well-accepted criteria of the typically neurotic act if we do so, for I feel quite confident that the delinquent act is but a special type—a syndrome, if you will—within the group designated “the neuroses.” Delinquent behavior can be seen to fulfill all of the criteria of this group. I say “*can*” be seen to do so because it is now our task to see wherein it does; wherein and to what extent we ourselves (I am talking now only about us in psychiatry and social work) have been unable to accept this notion; and why we have tended to be content with our older differentiated “neurotic” and “non-neurotic” categories.

Our primary difficulty, I feel, has been our inability or our unwillingness to apply the instinct theory in our consideration of the delinquent, as we have been able and willing to do in dealing with the neurotic. By “instinct theory” we are all aware that we mean that all behavior has, as its ultimate root and driving force, certain inborn predispositions to act or biological needs to fulfill, the fulfillment of which gives the individual pleasure, the frustration of which causes pain. We have in our psychoanalytic theories approached human behavior as if it were motivated by two such forces—the sex instinct and the *instinct of aggression*.

Now we come upon what is to me a very interesting—and illuminating—paradox. Although we have always noted the great opposition to an acceptance of Freud's concepts of the sexual drive—particularly infantile sexuality—having noted it, we have gone ahead bravely and scientifically and applied those theories and accumulated more and more data. And in the field of delinquency—though there has been (and still is) some reluctance in some quarters to assume that sexual deviations are *neurotic* manifestations of the sexual instincts, rather than just punishable misdemeanors—nevertheless, we have considered them as neurotic, and have pushed and pleaded for the professional diagnosis and treatment of delinquents so afflicted.

But, to return to our theme, here is our paradox: Although we have accepted and applied the knowledge of the *sex* instinct to delinquency, we have not been able—or, I suspect, we have not wished—to apply the instinctivist approach, and the rigid, but very useful criteria outlined above, when we are faced in our child with obvious demonstrations of the *instinct of aggression*. When we do this—*i.e.*, when we *can* do this—I think we will see that the division, neurotic and non-neurotic delinquents, is of little practical use—is, in fact, a definite hindrance to our treatment programs. It is obvious to all of us, of course, that the behavior of the delinquent, in 90 or more per cent of the cases, has seemingly nothing to do with the expression of the sex instinct, but has much—or everything—to do with acting *aggressively* toward the person or the property of another.

But why have we been loath to face this problem of aggression as dispassionately as we have learned to deal with what we have always *felt* to be a much more “unwholesome” drive—namely, the sexual impulse? It must be—if our analytic theories of resistance are of any validity at all—that we have not *wished* to consider the problem of aggression—whether it be in the delinquent or in any one else—because we are bothered by its deep, underlying, unconscious implications. In other words, we know full well that such a “blind spot” or “scotoma” in our thinking must be due to a serious fear of or distaste for the real meaning of the data or observations rejected—a meaning that threatens us with a possible loss of self-esteem as human individuals, causing us to make further modifications of the assumed rationality of our behavior and thinking. As a matter of fact, it should—if our suppositions are at all correct—have an even more serious connotation for us than our modern scientific concepts regarding sexuality. (And here we approach what I feel can be one of the contributions of the data gleaned in the study of juvenile delinquency to our fundamental knowledge of *normal* behavior—and particularly of aggression.)

If the delinquent act 90 per cent of the time is concerned not with the expression of the sex drive, but rather with the expression of the aggressive instincts, what is the exact nature or form of this expression as it is observed in our

boys and girls before the courts? Superficially, it is easy to answer this question, because from 70 to 90 per cent of such behavior, in any series of cases reported, has to do with *stealing*—general or specialized stealing—of property belonging to some one else. And may I say also that any one who at the present time proposes to deal in articles or books with the problem of the juvenile delinquent and does *not* concentrate practically his sole attention on the possible dynamic factors inherent in this most prevalent of all delinquent acts—stealing—simply is not professionally realistic. It would be comparable, for example, to a clinical pathologist's dealing with anæmia without a primary concern for the disturbed functions of the red cells.

Has this most frequent affront to the community's well-being—stealing—as an act, anything to do with aggression, and, if so, what? And, further, if stealing can be considered an aggressive act, can it always be justly labeled “neurotic” in that it satisfies all of the criteria of a neurotic act? Finally, what does this mean in relation to normal behavior?

In answer to the first question, I will state again that I have become more and more convinced that all of us have a tendency, when talking about aggression, to forget the deeper, unconscious, primitive—biological, if you will—significance of this act. I am afraid that we are accustomed—because we wish it so—to consider “aggression” more or less as a mere brushing aside of *external* objects that get in our way, of neutralizing *external* forces that thwart and hamper us, instead of regarding it as what it really is—a vital, *internal*, instinctive drive clamoring incessantly for repeated expression, expression that in itself must be pleasurable and thus is difficult to modify or repress.

The aggressive act in its simpler expressions is in reality a *destructive* act, and our first aggressive acts are of a distinctly destructive nature in that we act either to eliminate (destroy) an external object that confronts us, or to incorporate it and by so doing also eliminate (destroy) it. I am not referring here merely to the so-called “*counter-aggression*” that is alleged to be a response to some frustration instigated by some one else; rather, I refer here to *primary aggression*—a biologically grounded instinct, manifested by unicellular as well as multicellular organisms, to incorporate

and destroy—"destroy" in the sense that the material is taken up unto ourselves, made a *part* of ourselves through transformations that render it no longer completely a part of the environment external to us. This destructive (or "aggressive") impulse exists, and its presence is open to our citation and interpretation, at *all* levels of functioning in living organisms, from the strictest biological or even chemical functions of the cells to the myriad complexities of individual or even group behavior.

Stealing—the major element of all delinquent behavior—seems to us to be just such a *destructive* act in that it does symbolically involve the taking up unto ourselves and the transformation for our own use of that object or thing which *was a part of*—"belonged to," we say—some other person. This extension of ownership (and note the word!) is a destructive act in a double sense: it incorporates the object taken, and it to some degree symbolically destroys (mutilates, injures, or strips) the *person* of another. The power to steal is the power to destroy, and stealing is in essence a destructive act.

To pursue this concept further, property is conceived of in the unconscious as a part of some one—of some *person* beyond the self—and stealing it symbolizes unconsciously the *destructive* taking of it—wrenching it away from the person of another.

It is not possible, it seems to me, to account (1) for the stealing of boys who have everything material in this world that they need or want, or (2) for the *absence* of stealing in boys who live in the most undesirable neighborhoods, subjected to the most severe material deprivations, even lack of the barest necessities of life, by any theory that does not ultimately place this act in its proper meaning relative to the unconscious identity of property—all property—with the body of some person. Psychotherapy must start with this assumption.

All other "causes" of stealing—and the "causes," as the textbooks tell us, are multiple (poor training, deprivation, rejection, symbolic fetishistic stealing, desire to demonstrate physical prowess, and so on)—have their fullest meaning and relative significance for us only in the light of this concept.

As to the pleasurable aspects of this instinctual expres-

sion—not only in the simple incorporation of food and drink, but also in the complex destructive crimes against property—such aspects cannot be denied. We are sometimes puzzled, I think, in dealing with a delinquent boy, at the great patience and the vast, painstaking expenditure of energy often involved in the formulation, planning, and execution of an act of stealing. In spite of our common concept that stealing is a lazy man's way of making a living, I am sure that had we an accurate measure of energy output for such acts, from their inception to their successful or unsuccessful termination, we should find that the delinquent really *works* at his delinquency.

And we may note also that all this planning, all this scheming, is in itself a *pleasurable* output of energy. I have faith enough in the pleasure-pain principle as a working hypothesis to be convinced that were all this work *not* pleasurable, it would not be pursued. This pleasure, both in anticipation and in its eventual realization, is, I submit, the pleasure derived from the destructive (aggressive) instinct of man. And just as in the expression of the sexual instinct, the fore-pleasure becomes in itself an end to be sought—and sought for the pleasure derived over and above that inherent in the actual commission of the sexual act itself—just so, in the expression of man's destructive impulses in the stealing act, or in any other mode of expression selected, the pleasure in detailed preparation and planning constitutes the fore-pleasure of the destructive act and can, and often does, become the chief motivation of, or even a substitute for, the actual value of the thing to be stolen or the pleasure involved in actually depriving another of his ownership.

So much for the *instinctive drive*—the aggressive-destructive impulse—which we propose as the motivation in stealing, our most frequent of all juvenile delinquencies. Without some such formulation as this, I cannot see how we can ever begin to view the cases of delinquency in our everyday practice in clinic and agency with any degree of psychiatric sophistication at all. We will have to continue to content ourselves with essentially a non-dynamically oriented approach, except in those very few—comparatively, very few—cases of deviations in the expression of the *sex* impulses in which we already admit that the dynamic interpretations

are the only helpful ones in our understanding of the individual case.

Let us return now to our criteria of a neurotic act—constructed through the years mainly as a result of consideration of the *sexual* instinct—and very briefly note whether stealing, as an expression of the aggressive-destructive instinct, fulfills these criteria.

1. In the first place, destructive incorporation of material associated directly or indirectly, actually or symbolically, with the person of another is a mode of behavior designed to fulfill a biological need of the organism. In fact, we can argue that such aggressive-destructive impulses, through incorporation, subserve the very existence or life of the organism itself.

2. Because of the demands of society—at first represented by the parents, then by the community—the immediate, continued, unchecked, and unmodified gratification of this instinctive impulse is not condoned. Hence the human organism must get the best *compromise* (between gratification and denial) it can for the attainment of this pleasure.

3. Such compromises with our pleasurable aggressive-destructive impulses have to be both satisfying and satisfactory in relation to our biological make-up, on the one hand, and in relation to cultural insistences on the other.

4. That aggressive-destructive behavior which is either *not* satisfying or *not* satisfactory (or both) we may label neurotic or delinquent—and, to be completely accurate, it is *definitely* neurotic, with the added descriptive term “delinquent,” if we do not desire to place it in relation to *other* types of neurotic expression, such as phobias, and so on.

5. Delinquent behavior, just like other neurotic manifestations of needs, is disabling to the organism in some degree. It is disabling either because of the destructive (retaliative, punitive) impulses that it invites from the external sources attacked, or because in the child it definitely prevents a normally orderly future development, since it prevents the formation of a strong and healthy ego mechanism.

6. When the individual is considered in a *developmental* sense (genetically), unrestricted destructive incorporation is a type of behavior that is normal and expected in earliest infancy, and in its execution and its initial frustration it becomes indissolubly linked to the presence of and “owner-

ship" by some one beyond the baby itself. As development proceeds year after year toward adolescence, these aggressive impulses are modified, and each modification becomes an expected stage or phase in mature (for that age) behavior, which in turn is modified in the interest of more serviceable, more efficient, more socialized, or more moral behavior, as regards the expression of the child's instinct of aggression in the form of stealing.

7. Finally, then, the disabling or inefficient "neurotic" feature of the delinquent act of stealing is the *persistence* beyond seven or ten or fourteen—or whatever developmental age or stage we wish to select—of aggressive, incorporative behavior, the components of which should have been modified or repressed at an earlier stage of development. The fulfillment of this need was once efficient and permissible, but at a later date it is inefficient and prohibited. It is, again, an "emotional rest," a demand or need the infantile, primitive, or immature nature of which makes it just as irrational as it is compelling and insistent upon periodic expression.

And, parenthetically, it is just as much our task in therapy to uncover and expose in so far as we can this un verbalized—or, if you prefer, unconscious—destructive aggression inherent in the stealing act of the delinquent boy, as it is to bring to light the sexual motivations in any other neurosis of childhood. The more insight we can help the child to attain through this therapeutic procedure, the greater will be his ability to deal with these impulses as they repeat their demands. For here, too, you must replace an imperfectly understood "id" demand with meaning accessible to the ego, and hence subject to its control. And it follows, of course, that the more disabling the behavior, the more the need for intensive psychiatric treatment.

In the above discussion, then, through a shift in emphasis from the sex to the aggressive instincts, the undeniably neurotic characteristics of the act we call delinquent—and, in particular, of that most prevalent of all our delinquent acts, stealing—have been outlined. There is one other problem, however, which immediately comes to mind when the destructive features of delinquent behavior are emphasized, whether such behavior occurs in the neurotic or in the normal child—and that is the problem of passivity.

You will recall, if you think for a moment, that a large

percentage of our writings on juvenile delinquency—and notably those that have dealt with stealing—have been concerned with what *seems* to the writers at first glance to be the essential passivity or “passive oral receptivity” of the person who repeatedly engages in the thieving act. It is emphasized again and again that the child in stealing is trying “to get something for nothing”—that he is trying to recapture a state of blissful oral receptivity and passivity wherein gifts—symbolic of food and love and attention—are obtained *without an output of energy* or “a giving of himself” in return for such pleasures. It is, we have stressed, a sort of reactivation or continuation of that pleasurable, passive, parasitic stage or phase of development so characteristic of early infancy.

Somehow the continued actual study and observation of these cases do not seem to bear out these formulations in the theoretical sense, and proceeding along these lines in the practical aspects of therapy has never led to helpful or conclusive structuralization of the meaning of the child's stealing. The oral passivity theory always seems to be too “pat,” and, once voiced, it closes the door on the question what is the child to do about it, with an implied (and incidentally too often expressed) “So what?”

Again, the observations that we can make daily in these cases I am sure bear out my previous suggestions that boys and girls in stealing—like Gilbert and Sullivan's policeman when he is “poleceeing”—work hard at their delinquency. There seems to be little that is passive about the act itself, and in the light of our previous examination of this act, there is nothing passive either in the motivations, drives, aims, intentions, or purposes that give this act its so all-consuming power. This impulse is repeatedly carried out by children in the very face of and in spite of the *intellectually* appreciated fact that they have but about one chance in ten of not getting caught and, if caught, may face very severe punishments and losses of privileges and even of freedom itself.

To be sure, there are many delinquents who are described accurately as passive when their *total* personalities are considered. They do *not* respond to the admonitions of parents and other adults. There is often not a single instance wherein

their behavior can be called "aggressive" in the usually accepted sense of this term. They have suffered marked and prolonged deprivations, rejection, and frustration in early life, but counter-aggression does not seem to take the form of striking back with physical abuse and hostile defiance. On the contrary, they may be quiet, undisturbed, and undisturbable.

To account for such delinquencies by a theory of aggressive-destructive motivation, one may have to give some of our theories regarding passivity in people in general a severe wrench. It has always seemed to me that the so-called passive, oral, recipient delinquents were responding with the most deadly, most upsetting, and most impenetrable (therapeutically) type of *aggression* that they or any one can resort to in their fight against parents, colleagues, teachers, law-enforcement agencies, psychiatrists—namely, the aggression so aptly expressed by the passive response.

This heretical explanation of the rôle of passivity in human behavior is suggested not just to save a theoretical notion about the aggressive determinants in stealing, but because of two relevant and compelling observations. The first is that it is difficult to fit the commonly accepted theory into one's notions as to how organisms behave in their own best interests biologically by the use of a passive stage of inaction. Doing something—reactivity—is a basic attribute that distinguishes all living matter. That being so, the use of passivity at all would seem to be, not a waiting, static acceptance, as a defensive maneuver, till a more propitious moment arises, but rather in itself an aggressive response. Certainly an abundance of clinical material of the use of passivity in this fashion could be amassed to demonstrate this quality in the behavior of predominantly passive patients.

My second bit of evidence for the unconscious aggressive elements in an assumed passivity is the very definite *counter-aggression* that is aroused in most people when faced with an individual who resorts to such tactics. With our delinquent youngsters, such passive behavior almost never fails to arouse the anger of the parents, the court, the teacher, the probation officer, and all others who are endeavoring to understand and help the child. In other words, it is as if we, through *our own* unconscious motivations, understood full

well the aggressive nature of our clients' or patients' superficially non-aggressive intentions. And, of course, that is exactly what happens if we do not watch and guard our responses, and it is my feeling that just such unconscious responses on the part of well-intentioned (consciously) people have led to some pretty bad theories as to the true origins, meanings, and necessary treatment of such boys and girls.

At any rate, to leave this particular phase of our discussion, I hope that, though we *do* note the alleged "oral parasitic passivity" of many delinquents and criminals, there is considerable justification for the interpretation of such behavior as being, in reality, aggressive in nature. And here, again, I feel that such observations as these on delinquent children will enable us to make some contribution to the allied theories of human behavior regarding both normal and traditionally considered neurotic responses.

## THE DILEMMA OF PSYCHIATRY TO-DAY

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THIS paper was written by a staff member of a small child-guidance clinic that serves a large metropolitan area. The clinic was confronted with a demand for child psychiatric services altogether out of proportion to the staff time available. This article is the result of our endeavors somehow to meet that puzzling and discouraging situation.

Child psychiatry, however, is not an independent discipline, but an integral part of general psychiatry. The difficulties of our small child-guidance clinic are not an exception, but are the rule everywhere in psychiatry all over the country. The discrepancy between service needed and service available has become so great that a closing of the gap by creating more and better facilities and by training more and better personnel can no longer be the only answer. The present dilemma makes it clear that basically new methods of dealing with the problem will have to be created.

This article, then, is an attempt to clarify the position of psychiatry to-day in this dilemma.

The following are, very sketchily, the four important steps that, one after the other, have been taken by psychiatry since it freed itself from superstition and magical thinking:

1. The first step was description and stock-taking of the symptoms of mental disorders.
2. Next came search into their causes and exploration of the trains of events that bring them about. This was the period in which genetic-dynamic thinking in psychiatry was developed.
3. Hand in hand with the development of the dynamic point of view went attempts to create modern methods of treatment of mental disorders.

4. The next important step will be the development of effective methods of prevention of mental disease.

The historical sequence of these four phases was necessary and logical. None of these phases has as yet come to complete conclusion. The last of them—preventive mental hygiene—is still largely a dream of the future.

The achievements, problems, and shortcomings of these four periods deserve closer examination:

1. *Descriptive (Kraepelinian) Psychiatry.*—The great names of Charcot, Janet, and Binet in France, of Bleuler and Kraepelin in Switzerland, of Kretschmer in Germany, and of many others are connected with this phase of psychiatry. It was a time of careful, minute observation, description, and analysis of abnormal behavior; of organizing the wealth of the newly found phenomena in classifications of symptom complexes and syndromes; of developing dependable methods of observation and examination. The accomplishments of that period made psychiatry a science and made it teachable. They still form the background for all our clinical work and research.

The psychiatrists of that period were less successful in their attempts to find the causes for what they had described so well—*i.e.*, mental disease. Much energy and ingenuity were—and still are—spent in efforts to define personality disorders in terms of disease entities analogous to those of neurology, internal medicine, and all other subdisciplines of medicine. These endeavors, however, although based on hypotheses that later on proved untenable, were eminently heuristic. The psychopathologic concepts thus created had to be redefined, but the observations on which they were based still are meaningful.

This period of descriptive psychiatry did not bring forth successful methods of treatment for mental disorders. The most careful symptom description proved sterile without a therapeutically useful symptom interpretation. The now so fashionable contempt for “descriptive psychiatry” is aimed mainly at that therapeutic sterility of mere description and classification of fatalistically unchangeable illnesses. Observation and description, nevertheless, remain the basis of all

psychiatric work. This fact frequently is overlooked in our enthusiasm for the unlimited possibilities of interpretation of behavior. It is customary to treat with contempt an old-fashioned psychiatrist who is satisfied with describing the symptoms of the patient and with labeling his mental status with a diagnostic name. But the other mistake—interpretation of symptoms without preceding symptom description; in other words, erection of a huge structure of diagnostic speculation on a tiny basis of observed facts—is just as bad. Only a good integration of symptom description and symptom interpretation can bring about a real understanding of the individual psychopathologic process.

2. *Genetic-Dynamic Psychiatry*.—The main progress in psychiatry since the beginning of this century has been made in understanding what causes mental disease and how its symptoms develop in the interaction between the individual and his environment. The description of conditions gave way to the description of causes and consequences, and to the description of chronological sequences of events. The psychobiologic point of view of Adolf Meyer and the psychoanalytic point of view of Freud are the principal and most distinguished representatives of that era. We also have begun to integrate the findings of the school of Pavlov into our knowledge of psychodynamics.

This era of exploration of the chronological (genetic) and causal (dynamic) development of the psychopathologic process is perhaps nearing its completion. The machinery of normal and abnormal human development is intricate. Much work remains to be done before its functioning will be understood in sufficient details. We are, however, acquainted in broad outlines with the involved train of events that brings about the gradual development from undifferentiated helplessness at birth to mature independence at the end of the formative years. We also know what kinds of frustration, conflict, or threat to the existence of the still dependent child are apt to interfere with that development, and we know much about that complicated interplay of compensatory, defensive, and repressive forces that enable a person to make a new, although less efficient and sometimes insufficient, adjustment while the harm is being done and afterwards.

3. *Treatment Methods*.—The next natural step in the evolu-

tion of psychiatry as part of medical science was the development of treatment methods. As a matter of fact, this process went hand in hand with the scientific process of uncovering the dynamics of the psychopathological process. Psychoanalysis especially was created primarily as a treatment method. Its rich fertility as a method of clinical research, and its great contributions to our understanding of the psychopathological process, were in a way only a welcome addition to its usefulness as a therapeutic method.

However, psychiatric treatment to-day still is essentially restricted to a few basic principles—catharsis, “working through,” reëducation, the bringing about of emotional maturation, reassurance and encouragement, suggestion, manipulation of the environment. Use of these few basic treatment methods is not quite as simple as it may sound in this dry enumeration. One can use those methods after the manner of a bull in a china shop, inflicting terrible damage on the patient. One also can use them in such a way as not even to come near the difficulties of the patient, not to mention bringing about any improvement in his condition. The proper, effective use of these treatment principles has become an intricate science.

It is time to admit what is apparent anyway—that the results of our therapeutic methods are meager compared with the great amount of endeavor, thinking, and hard work invested. The radical cure for mental disorder has not yet been found, except for those early stages when the process still is wholly reversible. Otherwise, one can only alleviate; one can help people understand themselves, one can help them live with their difficulties, and one can remove harmful and painful symptoms.

It is doubtful whether a radical cure ever will be found for mental disease, once it is fully developed. Psychoanalysis and related methods have solved the problem in theory, by devising treatment methods that are in harmony with our present-day concepts of the causes of mental disease. These methods, if they aspire to be curative, have to attempt a far-reaching remodeling or reconstruction of the character of the diseased person as the only possible radical cure.

It can easily be seen that the difficulties of such a task are great and often forbidding. In a classical psychoanalysis,

layer after layer of the past emotional development of the person is explored in a slow, retrograde process until one arrives at the point where the harmful conflict originated. This is necessary because its beginnings are beyond reach otherwise. They are buried under a huge superstructure of undesirable consequences in the character development of the person.

This slow, step-by-step return to a point usually in early childhood is not carried through merely intellectually by bringing back to the memory decisive events and experiences of the past. The patient has to relive emotionally his past conflicts as he gradually wanders backward through his life. While doing this, he is asked also to revise and remold his attitudes toward people, toward events, and toward himself at the very point where those attitudes were created. In its sum total, the procedure is a colossal process of "regression" to a critical point, usually in early childhood, and then of rematuration on a healthier, unneurotic basis. The therapist has to be careful to let regressions and rebuilding take place only in small steps and in restricted areas at a time, in order to keep the individual well integrated and on a sufficiently high level of personal maturity.

Such a radical and exhaustive procedure is extremely time-consuming and expensive. Only a few of the well-to-do can afford it. Even setting aside the economic limitations, however, the contraindications against the method are numerous. The patient may be inaccessible or unwilling to go through with the treatment; he may lack the emotional or intellectual qualifications; he may be in so precarious a mental condition that such an incisive method is too dangerous; the disease may be too far advanced or the mental disintegration may already have set in. As a result of all these limitations, the overwhelming majority of the existing cases of mental disorder are not accessible to treatment by psychoanalysis and related methods.

An intermediate step between psychiatric treatment and preventive mental hygiene is early treatment. Since the day when Freud insisted that all neurosis starts from a "trauma" in early childhood, the slowly progressing findings of dynamic psychiatry have pointed with singular insistence to childhood as the decisive starting point for the over-

whelming majority of all neuroses and mental diseases. The individual character of the future adult is formed during that period. Certain types of frustration and conflict during these formative years have consequences far beyond their seemingly small importance. The event can be compared with an avalanche. A series of small first incidents becomes the cause for more events, for secondary conflicts and vicious circles, for a spreading of the conflicts over other aspects of the person's life, for the development of lasting unfavorable attitudes, personality traits, and habit formations. Eventually, after years or decades of struggle, it becomes about as difficult to single out the original conflict as it is to find in the huge conglomeration of ice and snow down in the valley the small aggregate of snow crystals that high up on a mountain slope set the avalanche in motion.

It is obvious what step had to be taken as a logical consequence of these findings: If the original conflict is so difficult to reach later on because it is hopelessly buried under the superstructure of its consequences, why not try to reach it when it still is isolated and uncontaminated, at the moment when this whole unfavorable development is just starting?

This means psychiatric treatment in childhood. The step was not taken all at once, but gradually. Healy and Aichhorn went back to adolescence. Anna Freud, Melanie Klein, Sterba, and others inaugurated the period of child analysis. The child-guidance movement started and developed in this country in the twenties and thirties of this century. The importance of play as a tool in psychiatric treatment of children was discovered in the thirties and quickly assimilated by many therapists of all schools.

This new venture of psychiatric treatment of children inaugurated a period of intensive study of the dynamics of the normal and abnormal personality development of children and adolescents. This period is far from being concluded. One of its definite results is the recognition that the original conflict that starts the psychopathologic development always involves two parties—the child, on the one hand, the persons who bring him up (usually, of course, the parents) on the other. The Philadelphia School, under Frederick Allen, drew the logical conclusions. They pointed out that it is futile to try treatment of the child without simul-

taneous treatment of the parents. If child and parent are involved in the original conflict (a fact that can no longer be doubted), then they both have to work on its resolution in the treatment process.

This thought can be carried a step farther in those cases in which one has a chance to attack the original conflict at a still earlier period, when the child still is normally reacting to a harmful parental attitude. In those very early cases it often suffices to work merely with the parents, as, for instance, is done in well-baby clinics and by psychiatrically oriented pediatricians.

All that is not merely theoretical deduction, but is supported by practical experience. It is the rule—although with many exceptions—that psychiatric work with adolescents has to be focused mainly on the adolescent himself. At that period the parents already have ceased to be the main or the only dynamic factor in the undesirable development. The neurosis usually has become self-perpetuating. Very roughly, children between the ages of five and eleven are best suited for the classical method of simultaneous treatment of parent and child as developed by the Philadelphia School. This is in most cases the time when the original conflict is in full development, but is not yet too much overshadowed by secondary developments. Before the age of four or five, the main focus of psychiatric treatment is on the parent, the child readily changing his attitude with a change in the parental attitude.

This closes the circle and we find with embarrassment that it has brought us back to where we originally started. Finding psychiatric treatment of adults impracticable or unfeasible in a great majority of cases, we went farther and farther back into childhood, as near as possible to the starting point of the original conflict. At that point we realized that treatment of children is ineffective unless the parents are included, which confronted us with the same old problem that we had tried to escape—the difficulties and impracticabilities of psychiatric treatment of adults. Only we are in a child-guidance clinic now and want to treat the adults not for their own sake, but in order to prevent them from transmitting their own emotional difficulties to the next generation.

The psychiatric treatment of the adult has thus become

"child centered," which makes necessary a changed technique. But the qualifications for treatability are hardly less restrictive and forbidding than those in straight psycho-analytic treatment of adults. These restrictions have proved very necessary in practice. Attempts at combined treatment of children and adults in cases that are not well adapted to treatment lead only to disappointments and failures. As a result, only very few of the children who are in need of psychiatric treatment can receive it. In many, many instances the inaccessibility of the parents or some other forbidding environmental factor prevents effective action, although the children obviously still are flexible and plastic, and, therefore, could readjust with relative ease in a less harmful situation.

This is the place to say a few words about a rejected step-child of child psychiatry. It has been called "environmental manipulation." The very ugliness of the expression reflects the contempt of many progressive psychiatrists for that method.

The idea underlying the method is simple and obvious. If it is taken for granted—as it is in modern psychiatry—that environmental, and especially parental, influences are at the root of most behavior disorders in childhood, then it should be possible in many cases to bring about an improvement, perhaps a cure, of the disorder by deliberately changing the environment in such a manner that the harmful factors are removed or that indispensable factors that so far have been missing or insufficiently represented are supplied. The child may even be brought into an altogether new therapeutic environment.

Methods based on this principle are in extensive use in all other branches of medicine. Innumerable physical diseases are treated by such removal of the harmful cause of the disease or by replacement of the deficient factors. However, in order to make such a treatment method useful and reliable, the harmful or deficient factor must be well defined scientifically, and precise methods of application must be developed. Otherwise, its use remains an uncertain, hit-or-miss affair. I am afraid that our attempts at environmental manipulation still are in the primitive stage. It is the same difference as that between treating malaria by removing the

person from the "miasma" and letting him chew the bark of the cinchona tree, and treating it by methodically and scientifically exterminating the transmitting mosquito over large areas and giving the patients well-defined amounts of chemically pure quinine or atabrine.

The method of "environmental manipulation" is, with notable exceptions, still in the stage of crude experimentation. The cases in which it is indicated and the conditions under which it is efficient have as yet been only vaguely defined. We speak of a child's need for affection, for security, for warmth and acceptance. This is about as clear as the old concept of a "miasma" in malaria. Our knowledge as to how foster homes and institutions should be constituted in order to be therapeutic is still in the stage of exploration and about as vague and undefined as the quinine was in the bark of the cinchona tree. We send children to institutions and foster homes and hope for the best. We do not even know for sure in how many cases the move is beneficial and in how many it is harmful.

A vicious circle has arisen out of the contempt of psychiatrists for "environmental manipulation." The method has remained undeveloped and the resources in that respect, foster homes as well as institutions, are scarce and often of very poor quality. This lack of therapeutically suitable substitute homes has kept the method inefficient. A host of children to-day are being made unhappy and damaged irreparably in inadequate institutions, foster homes, and adoption homes. These deplorable results, then, are used as an argument against the method and have encouraged further neglect of its development. The fact is overlooked that, whether we want it or not, many more cases have to be treated by placement in a new environment than by intensive psychiatric treatment.

4. *Preventive Mental Hygiene.*—All this seems to amount to a gloomy and seemingly defeatist picture so far as concerns providing better coverage of the population with psychiatric service. Yet it is better to realize early that one is in a dead-end street than to drive on. At least one can get out and make a new start in another direction. Such situations of seeming deadlock have arisen before in the course of the successful solution of other major health prob-

lems. One important point ought to be kept in mind—not many diseases can be easily and completely eliminated, once they have established themselves in a person. The histories of our successful fights against epidemics and against slowly spreading non-infectious illnesses are good examples in point.

The progress of events often has been like that of our fight against mental disease. Take the case of tuberculosis, syphilis, and cancer. In each instance, the first therapeutic attacks were directed against the fully developed illness. They brought some, even considerable, success—rest cures and surgical treatment of pulmonary tuberculosis; surgical and radium treatment of cancer; salvarsan and its derivatives, malaria therapy, and so on, in the case of syphilis. But after some time one came to realize in each case—just as in the case of our fight against mental disease—that all these methods of treating fully developed cancer, syphilis, and tuberculosis, although most beneficial in many individual cases, are time-consuming, uneconomical, and uncertain as to effect.

Above all, they proved ineffective when it came to fighting the respective illness as a major national health problem. Their use did not palpably influence the morbidity rate of the respective illness. As in psychiatry, the next logical step in each instance was an attempt to solve the problem by treatment at the earliest possible moment. This always brought a considerable improvement of the existing treatment methods. Yet it did not further the solution of the urgent basic problem—how to prevent the illness from spreading.

In the case of each of these illnesses, the problem could be solved, or will be solved, only by preventing the disease from invading the body, not by fighting it after it has entered. I hasten to add that this fact does not release medical science from the responsibility for improving the methods of treating the already tuberculous or the already syphilitic or cancerous patient—or in our case the treatment of those persons who already are suffering from mental disorder. Yet, if one wants to fight a rapidly spreading illness, it has to be done by preventing the propagation of the disease rather than by treating its victims.

Mental disease has become such a rapidly spreading ill-

ness in our civilization that the need for an effective, practicable method of combating it has become increasingly urgent, not only from the point of view of the suffering individual, but also from that of the health and efficiency of the nation and of the various communities. The full extent of the problem has been understood only lately.

We have come to realize that not only insanity, but also alcoholism, criminality, and habitual idleness are the consequences and symptoms of mental disorder. We have come to realize also that the outright insane, the alcoholics and the addicts, the criminals, the down-and-outers, are merely the already defeated ones who have disintegrated mentally, or who have given up the fight, or who have chosen a socially unacceptable way out of their otherwise unsolvable conflict. There is a much larger number of individuals who have come to terms with their emotional conflicts on a less conspicuous and less objectionable basis than insanity, criminality, or alcoholism. They are, nevertheless, suffering—and often suffering horribly; they are less efficient, often altogether incapacitated; many of them are very unpleasant to live with, and many of them are very harmful as members of a family and especially as parents. The experiences of the war have shown that the number of these persons—not overtly insane, but seriously maladjusted or neurotic—is staggering. It goes high up into the millions on a national basis. We know that a large percentage of the children of these persons will be seriously maladjusted or neurotic, too, not because of a hereditary transmission of neurosis through the germ cells, but because of the influence of their neurotic parents on them *after birth*.

Preventive mental hygiene is concerned with preserving the mental health of healthy people, and not with treating the mentally ill. There has been a vigorous initial movement toward the development of methods of prevention in psychiatry during the last few years. It still is to a large extent in an exploratory and experimental stage. The World Health Organization of the United Nations, The National Committee for Mental Hygiene, the United States Public Health Service under the National Mental Health Act, and several other large foundations have taken the lead in this area. A great deal of educational work is done on a nation-wide and interna-

tional scale—in mental-hygiene societies, among physicians and other professional people, in parent-teacher associations, church groups, and other groups of similar character, by speeches, lectures, leaflets, and books. There are promising, though small, beginnings with well-baby clinics, habit clinics, and similar institutions for the very young child, in which pediatricians, social workers, nurses, and psychologists join their efforts in a general preventive-health program that includes increasingly the elements of a preventive mental-hygiene program.

A healthy movement to make the teaching in schools less scholastic and better related to the realities of life is under way. The battle against child neglect and juvenile delinquency has been joined by juvenile courts, by a few progressive institutions for "problem" children and delinquent adolescents, by group-work agencies, and by other welfare institutions.

The social workers have done more spade work than any other group, so far as translation of preventive mental-hygiene programs into practice is concerned. The best of them have made use of the tools and experiences of dynamic psychiatry in family case-work, in work with neglected and delinquent children, in the intricate and difficult task of child placement, in work with unmarried mothers and in adoption work.

These and other beginnings and adventures seem to be the points at which major developments in preventive mental hygiene are to be expected soon. It is possible that some of the experiments that are now in process may prove ineffective and may have to be discarded. The worth-while ones will have to be developed and multiplied. Above all, altogether new avenues of attack will have to be found. The classical methods of preventive mental hygiene may still have to be created.

## MANIFESTATIONS OF MATURITY IN ADOLESCENTS

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IN our culture the immaturity of adolescents is over-emphasized. Being so concerned with their faults and lapses into childish behavior, we forget that a large number of teen-agers are more intelligent, more capable in making and carrying out plans, and more emotionally mature than some of their parents and teachers.

"I think one of our chief difficulties," a seventeen-year-old boy said, "is having people realize that you are no longer a little kid. The teachers try to do the thinking for you as if you could not think for yourself."

Many young people have to deal with "problem parents and grandparents" and "problem teachers." And they do it fairly well. In society as a whole, youngsters to-day are "striving against the massed immaturity of adults."

Adult conferences on international relations, coördination of welfare agencies, mental hygiene, and other vital problems of to-day have been disappointing. Let us turn to young people for their ideas and assistance. What they tell us is direct, concrete, realistic. We have much to learn from them.

They have given us many examples of emotional maturity. Although maturity is manifested in many ways and in different degrees in various individuals, a few characteristics of the mature person may be mentioned:

1. Ability to feel with others, to see things from their point of view, and to be creative and happy rather than antagonistic or indifferent in one's relations with others.
2. Objectivity toward one's self, "ability to recognize and accept one's own emotions as natural,"<sup>1</sup> to project hypotheses about one's behavior, submit them to test, and, according to the results, further develop or discard them.

<sup>1</sup> From a paper read by Dr. John A. P. Millet at the annual conference of the New Jersey Welfare Council in New York, December, 1948.

3. Ability to select suitable, worth-while, long-term goals and to organize one's thinking and acting around these goals.

4. Ability to make adjustments to situations; a certain amount of "rôle flexibility" is necessary to bring one's concepts into line with reality.

5. "Ability to meet unexpected stresses and disappointments without experiencing emotional or physical collapse, and without abandoning established lines of interest and activity."<sup>1</sup>

6. Ability to give as well as to receive affection.

7. Ability "to form opinions based on sound reasoning and to stand up for them, without abandoning willingness to accept such compromises as do not violate fundamental convictions."<sup>2</sup>

The following compositions, from among over two thousand written anonymously by unselected high-school pupils, are examples of the way adolescents face their everyday problems.

The normal number-one problem of adolescents is that of boy-girl relationships. The ability to see the other person's point of view and to achieve satisfaction from interpersonal relations is an evidence of maturity shown in the following composition by a fifteen-year-old girl:

"My problem concerns a love affair and school work. Two weeks before school opened, I met a fairly attractive boy. I met this boy through another friend. This boy came to my house several times; we went to quite a few parties and dances together and to the movies twice. We called each other often on the phone and talked about the future and our plans; the more I talked to him, the more we seemed to be so much alike. When school opened, I seldom saw him or even had phone calls from him. As a result, I lost interest in my school work, because of worry over him. My marks came closer and closer to failing.

"One day late in the afternoon this boy called me up and said the reason for not coming to see me was that he was working after school. He also said that several of my friends told him for the past two weeks I had looked worried and had had no interest in anything. He said he hoped I had not taken him too seriously and that the things we said and did together were only the usual things kids our age do. He said first we must learn, think, and then act, not act, think, and then learn. He said he had found true friendship in me and admired me very much, but we were still young and had a right to enjoy life. We discussed many other interesting opinions.

"After thinking this over I stopped being worried and took more

<sup>1</sup> *Ibid.*

<sup>2</sup> *Ibid.*

interest in my school work and home activities. When this boy comes around to see me, we have fun together and when he doesn't come, I do not worry because I know I have not lived half of my life and I know that he will not be the only boy in my life. I passed the first tests with one C+ and the rest A's and B's.

"Thanks to my friends who were interested in me and thanks to this boy's concern for my well-being in the future, I have succeeded."

Another aspect of achieving success in social relationships is illustrated by a youngster who had experienced difficulty in holding up her end of the conversation. By successfully solving this problem, she arrived at a mature point of view regarding life's problems in general:

"My problem was one that perhaps has come to almost every one between the ages of fourteen and twenty. It was the task of holding my end of a good conversation up, and 'getting into the click' of the group, so to speak.

"Although I tried, I always felt deep inside that I was being slighted, that some teen-agers were satisfied only with their own private gathering of friends. I got along well with fellows, and had many dates, but when we would triple-date, and the girls were strangers to me, they seemed to climb into their own little shell, making me feel as if I didn't belong. I could never start the conversational ball running in my direction.

"This predicament confronted me just a few weeks ago. The girls were sorority girls, and talked of the various things that happened at their sorority meetings, leaving me at a loss, since I was not in their sorority.

"Since I have been up against this problem again and again, I decided to find things to talk about that they would all be interested in and that would let me in on the conversation. Thus, the afternoon before my date was devoted to listening to a college football game, and reading thoroughly the news and movie reviews. I even took a couple of notes and recited aloud the topics I would talk about that evening.

"Does this sound silly? Well, it worked! I learned a lesson which I shall never forget. If you prepare yourself a little for whatever obstacles you know lie ahead, it will greatly aid you in overcoming them."

A periodic crisis in the life of high-school pupils is report-card day. Many youngsters, having previously experienced punishment for getting poor marks, dread taking their report cards home. Some youngsters, however, have learned to be quite objective about themselves and their parents and forestall disappointment by lowering their level of aspiration. One writes:

"When I bring home my report card, I do not expect praise. My parents, in my estimation, have just the right attitude toward it. Instead of getting a lot of praise for my good marks, my attention is

called to the bad ones and they discuss what can be done about them. This, I believe, is the best thing they can do, although when they do not compliment me on the good ones I feel hurt once in a while, but after thinking it over I realize it is better for me if I don't expect praise until my work is all above reproach."

Another high-school pupil met an academic crisis by seeking the most expert help available:

"When I first entered high school, I was very excited. I felt very grown up and important. High school to me was just football, baseball, and basketball games, plays, movies, and clubs. I soon realized differently though, when report time came around. I discovered two very ugly F's on my report, one in English and one in typing. I was at a loss as to what to do. I discussed it with our counselor and she helped to straighten me out. She told me that by taking an extra half credit a semester I could make these subjects up and then take speech in order to make up my English, for English is one subject that you must pass. Now I am in the twelfth semester and have made up the credits in typing and English. By my last semester I will be all straightened out and I now realize that the sports and fun of high school are important, but not as important as your homework and classwork."

Ability to view oneself objectively and to analyze the situation may be illustrated in connection with another problem—that of drinking among teen-agers. Few adults have thought about this question as maturely as this sixteen-year-old boy, who wrote:

"In my crowd the problem was drinking. They thought it was smart to have beer parties, or to have weinie roasts where a bottle was included. I think it is wrong for teen-agers to drink. It is bad for our health and it is not smart, but what is one to do or say when every one else in the crowd likes to drink? A person feels different and left out when he isn't like the others in his group. This was my problem and it weighed heavily on my mind for a long time.

"Then I started observing the other people in my crowd. The more I thought about it, the surer I was that they drank, not because they really like to, but because it gave them a thrill to indulge in something which was thought wrong for teen-agers, and because they didn't want to feel different from the group, as I had felt. I found that teen-agers who drank were not the ones who were respected. I talked it over with several of the other kids in our crowd and I was glad to hear that they shared my views on the subject.

"This is a problem which confronts most of the teen-agers of to-day at one time or another, and it is an important one. I really believe that if every person who drinks would analyze his views on the subject and find out why he does and what he gets out of it, there would be fewer cases of teen-age drinking in America to-day."

Another manifestation of maturity is the ability to select goals and long-term purposes and make progress toward

their realization. The following account of a fifteen-year-old's method of making educational and vocational plans might well be given as a model to other high-school pupils:

"My most disturbing problem is the one of selecting my lifetime occupation and the college or university in which I will continue my education. After much thought concerning this great problem, and many changes of thought, either for financial or personal reasons, I decided on a plan of attack.

"First, I discussed the financial part of the problem with both parents and an older sister. Then, finding out how much I would be able to spend per year, I visited the school guidance counselor. From her, I learned of my strongest subjects and my general standing on intelligence tests. With this knowledge, and a knowledge of what I liked to do best, I narrowed down the field of occupations to obstetrician or to teacher of physical education on a college level. Next, I returned to the counselor, and with her aid, and by a process of elimination, I selected several colleges within my financial status, and wrote to them for catalogues of information, in order that I might find the one best suited to me.

"As yet, I have not received a reply from each of the schools, but I am sure that when I do, it will no longer be a problem for me to select my life's work."

Ability to meet disappointment head on, as it were, and take the necessary action, is illustrated in this account written by a seventeen-year-old girl:

"Recently I have been faced with a problem which seemed of great importance to me. I will graduate in February and have every hope of entering nursing school the same month. When I obtained information from the hospital where I hope to train, I discovered that I was lacking one credit in social studies. This came as a blow to me because I wanted so much to start in February instead of putting it off for a whole semester.

"I don't believe that the lack of credit was my fault and I don't wish to put the blame on my adviser, but I had stated when I first came to this school that I wished to enter either medical school or nursing school. Since my adviser knew this, it seems to me that she should have made provisions for it in my long-range program.

"When I spoke to the director of nurses about it, she told me that if my marks were high enough, I would be able to enter the school and make up the credit during my training. I hope I will be able to do this. If not, I must wait until September.

"I believe that the school should have persons well equipped to advise the pupils as to the subjects they should take. They should know the requirements for the different schools and their courses. If they are not sure, they should have the information at hand where it could be found easily, before giving the wrong advice."

Here is another example of a young person's ability to meet the most severe adjustment in her family relationship

without emotional disorganization. It is a problem that many children have to face to-day—the problem of their parents' divorce. Helen described it in this way:

"When I was sixteen, I had a problem of having to face the fact that my mother and father were going to separate. This was something I couldn't do a thing about. The fact of my loving them both and having to be separated from my father hurt me more than anything in this world.

"Well, I couldn't help but feel bad. When I went to school, the girls were always talking of going this place and the other with Mother and Dad; it made me feel sort of out of place. At meetings in school my mother and father used to go together. But now my mother is the only one that goes to the P.T.A. meetings. Those were some of the things I had to face.

"This was the way I met this problem: I had a long talk with my mother and she explained why she and my dad couldn't make a go of the marriage. I also had a talk with my father and heard his side of the story. Then I said to them that I was more than sorry that they had waited until I was able to take the thing so to heart. Then I decided, since the thing was not going to work out, that I'd do things to stop me from thinking of my home life. So I joined clubs and went to dances and movies. I soon (not completely, of course, for I never will) forgot the unhappiness of the situation, but I have the same affection as always in my heart for them both."

Helen met this situation in an exceptionally mature way. She tried to understand both parents. She began to live her life more independently of her parents as teen-agers eventually will have to learn to do. Most important of all, she went through the experience without bitterness.

Ability to form opinions based on sound reasoning and to stand up for them was demonstrated by this socially minded fifteen-year-old girl:

"Although our teen-age problems seem so unimportant to grown-ups who have such serious problems, our problems are as serious to us and as confusing as any problems are to adults.

"My problem is that I have been asked repeatedly to join a sorority and have refused all bids. Unfortunately, the majority of teen-agers in this town are members of a sorority or fraternity and those who do not belong are more or less social outcasts.

"Though I have many friends in school, I have only three very close friends. I go out every week end with different boys who are not in fraternities, but I do not get a chance to meet other boys. I definitely am missing some aspects of social life and I am wondering if my reasons for not joining a sorority are justifiable and wise.

"My reasons are that sororities and fraternities are undemocratic and snobbish. The system of 'black-balling' a member is inexcusable. I have seen girls join sororities and become so dependent on the sorority's name that they lose all individuality.

"I am independent and do not want to limit my friendships to one certain group of people. I do not like the idea of being treated like dirt as you are during the long 'goating' period.

"I am doing what I think is right, but I am not sure whether it is beneficial to me and if I am just trying to be righteous and 'different.' To me the only benefits sororities hold are social benefits and those are limited since you only meet one type of person."

What can the secondary school do to help adolescents develop the emotional maturity of which they are capable? Much can be done through providing experiences that evoke mature behavior: "We do not know how high we are till we are called to rise." Almost all pupils can carry more responsibility of various kinds than they are given at present. They need more opportunity for making choices and decisions. So often pupils say of counselors, "They told me what to do." Pupils need opportunity for beneficial interaction in groups—in informal classes, committees, and clubs. Children learn from one another. They need more encouragement to be creative in their work and in their relationships with people.

In order to be mature in this day and age, young people need to understand the world of nature and the world of man. Through their study of applied physical sciences and social sciences, they should acquire a sense of confidence and a conviction that "the fundamental principle of democracy is equality . . . equality of burden as well as equality of opportunity." They also need to understand themselves. Through skillful counseling, they can learn to use the resources within themselves to realize their most acceptable selves.

## PRESENT-DAY STATUS OF MEDICAL- PSYCHOLOGICAL ASPECTS OF ALCOHOLISM \*

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**W**ERE the great city of Chicago to-day emptied of its entire population by some catastrophe, it could be totally repopulated to-morrow by the alcoholics of this country and their blood brothers, the heavy social drinkers—who, all too frequently, are joining the ranks of the alcoholics.

This is not by any means an exaggeration, for there are an estimated three-quarters of a million alcoholics in the United States and more than three million so-called heavy drinkers, who are less of a problem, but only by comparison.

Workers in all fields of public health and welfare definitely feel that alcoholism is a major factor in the destruction of family life, in children's behavior problems, juvenile delinquency, and general community turmoil.

Although alcoholism is now generally recognized as, in most instances, a symptom of emotional illness—ranging from a major psychiatric reaction to an attempt to escape from a dreary existence—and is definitely to be distinguished from social drinking, nevertheless, the dangers of heavy social and heavy daytime drinking must be more thoroughly understood.

In industry, including the liquor industry, heavy social drinking produces inefficiency, absenteeism, and costly errors of judgment.

*The Alcoholic.*—When we describe an alcoholic as a sick person, the description is accurate. But like those suffering from other illnesses, many alcoholics can be "cured." Some even work out their own recovery.

Just what is an alcoholic? So far as any special alcoholic personality *type* is concerned, there is none. By and large—excluding the total psychopath, the psychotic, the epileptic,

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the deteriorated, and the feeble-minded—the alcoholic of to-day has better than average intelligence, but a poorly integrated personality, with marked emotional instability and inability to accept frustrations.

His unsatisfactory interpersonal relationships and emotional immaturity, which places self above all else, produce a need that he thinks can be satisfied through the use of alcohol—as a narcotic, an anæsthetic, or as a release from the bonds that tie him to a humdrum, everyday plane of living.

But, unlike the social and even the occasionally intoxicated drinker, alcohol dominates him to the extent that it drastically affects one or more of his essential life activities, such as his ability to maintain economic equilibrium, his reputation, or the harmony of his home life. Loss of insight, or of the ability to evaluate what damage his drinking is doing to himself and others, is a usual consequence.

For any or all of these reasons, the alcoholic should be recognized as a sick person who needs competent psychiatric treatment.

How he got that way in the first place may be just as complicated and hard to define concretely as will be the treatment needed for his cure. Actually, an alcoholic is developed by many interrelated factors, together with his biological make-up and metabolism. He is the product of his ancestors, their racial background, drinking, and other life habits.

His own personality, of course, results in part from his early experiences in life—his hurts and happiness—and also his later experiences, which may be profoundly formative. Among these are vocational factors, emotional experiences, religious attitudes and convictions, ideologies, the social drinking habits of his friends, and the social pressure to drink among friends and business associates.

Then there are his own inner drives, striving against inhibitory barriers.

To round out a picture of an alcoholic, in so far as that is possible, it may be said that studies of both men and women often reveal the following characteristics: (1) self-pampering, (2) frustrated strong urges, (3) a habit of avoiding responsibilities, (4) various emotional hurts, (5) psychosexual frus-

trations and hurts, (6) the emotional urge to take the brakes off certain sex drives and allow them free range.

Also, psychiatric study may often bring out marked insecurities constantly active in the personality, and identification and imitation factors rather than any inherited tendency to be an alcoholic.

Alcoholism may result, in some cases, from heavy social drinking, from bodily changes and the strains and griefs of life. According to some investigators, on the other hand, alcoholism may be evidence of latent or overt homosexual ingredients or of intense, unconscious, self-destructive tendencies.

The pathology of alcoholism, as such, is found in disorders of the neuropsychiatric field, including encephalopathies of various types, neuropathies, and behavior deviations shown by personality, emotional, or thinking disturbances of the individual's usual behavior or that commonly accepted as usual by society.

*Treatment.*—Treatment of the alcoholic patient depends, of course, upon his condition. Delirium tremens or pre-delirium tremens, in cases under fifty-five years of age, uncomplicated by bromides, pneumonia, or permanent obvious organic brain changes, should be treated immediately—on the spot—by the administration of 1,000 to 2,000 cc. intravenous of normal saline with 50 cc.'s of 50 per cent glucose per 1,000 cc., insulin, and a heavy dose of vitamin B<sub>1</sub>. Appropriate sedation of phenobarbital and dilantin is used to prevent convulsions resulting from the abrupt withdrawal of alcohol. If the office is unequipped to treat this condition, the patient should be placed immediately in a psychiatric hospital.

Non-acutely intoxicated patients may be examined at the initial interview. This examination should include the usual complete psychiatric history from birth; the psychiatric examination; a thorough physical (including neurological) survey; and thorough psychological testing or "screening through." Whenever possible, the mate should be examined, in the same way, to help obtain an over-all understanding of the entire situation.

Personality structure is evaluated through use of the Rorschach analysis, the Murray thematic apperception test,

and the Goodenough draw-a-person test. Intellectual resources are investigated by the complete Kohs blocks test and by the Bellevue-Wechsler adult-intelligence measurement scale (which is also useful for assaying the sensorium and spotting early signs of possible organic states). Other special laboratory tests may be required in certain cases, such as, for example, "brain-wave" tracings.

Of all the aids to understanding a given personality in action, the Rorschach ink-blot analysis is the most helpful, for its findings reveal definite personality traits and tendencies of which, often, the patient himself is not aware.

The findings of all the examination procedures and surveys help determine how and where the patient should, ideally, be treated.

In each individual case the following factors must be evaluated and carefully weighed: (1) level and quality of the patient's intelligence; (2) presence of any organic brain changes or deterioration; (3) level and quality of emotional maturity; (4) quality and intensity of the individual's desire to stop drinking; (5) presence or absence of any major psychiatric illness; (6) presence or absence of any minor psychiatric illness; and (7) life problems and reaction to emotional strains at the time, either at home or in business, which may be too much to cope with.

*Psychiatric Treatment.*—At the outset, the patient and his family should be told that total abstinence is one part of the goal.

It should be remembered that treatment of alcoholics is not an exact science, nor does alcoholism have any specific. It just is not possible to look into a textbook and find a formula that will give automatic results. Each patient must be taken as a wholly new and entirely different problem, the solution of which is unique.

The psychiatrist must win the complete confidence of the patient, and this will not be possible unless he is plastic, tolerant, and careful to avoid a brusquely dictatorial manner which might create a resentment, ruinous at the outset.

In this connection, the attitude of the patient's mate is extremely important. Since the alcoholic patient needs to understand himself, and also, in many cases, to know that his

cure lies in this and in developing emotional maturity, discussion of specific situation problems is strongly indicated.

Mention has been made of the fact that some alcoholics have stopped drinking by themselves. Others have been helped by religious groups, lay groups, and lay-and-religious groups. Even the old "Keeley Cure" helped many an alcoholic, and some now recommend a conditioning or an aversion treatment without psychotherapy; while others, with deeper interest, use this method in order to get a beach head on the patient and then follow up with psychotherapy.

The author feels, as a result of personal discussions and conversations with other therapists, that—generally speaking—deep, lengthy psychoanalysis alone, hypnosis alone, hypnoanalysis alone, narco-analysis alone, and the assaultive therapies alone—such as chemical, drug, electric shock, or various types of lobotomy—are not helpful in the treatment of alcoholism.

Generally speaking, competent, specially trained psychiatrists are needed. Ideally, and in most cases, treatment should be in a farm situation.

To summarize, an alcoholic is a sick man, but his addiction to alcohol is itself a symptom rather than a disease. Alcoholism may be part of any psychiatric clinical reaction or may be produced by any psychiatric clinical reaction. It presents itself like the top of an iceberg. The great need is to understand what lies beneath.

The Rorschach, or ink-blot, analysis has, with a great deal of consistency, presented the following in the non-psychotic, non-feeble-minded, and non-deteriorated alcoholic patient—or the alcoholic of to-day:

A high-handed approach and aggressive drives without any clear-cut goals; an immature attitude regarding other people in positions of authority; strong to violent emotional forces inadequately controlled by judgment; basic difficulty in getting on with others; tendency to shirk adult responsibilities; lack of perseverance; oversensitiveness in regard to self; tendency to blame the environment (or paranoid trends); stubbornness and contrariness; deep inner anxieties.

Medical-psychological treatment of the alcoholic consists of

obtaining a thorough understanding of him, as a person and in his particular life situation, in order that one may be of aid in his rehabilitation, both the patient and his family knowing at the outset that one of the goals is total abstinence.

Some patients are helped by daily subshock injections of insulin, over a period of many months, and do not require extensive or deep or even brief psychotherapy.

Experience with non-deteriorated alcoholic patients indicates that successful results are accomplished through the following factors: (1) careful selection of patients, as above indicated; (2) personality of the psychiatrist; (3) vitamin and insulin therapy in controlled dosage with sedation as indicated to aid on the physical side; (4) formal psychotherapy (distributive analysis or brief psychoanalytic therapy), with emotional reëducation; (5) interpersonal relationship of patient and therapist; (6) suggestive influences; (7) interviews with the mate and close relatives; (8) intangible, but dynamic factors, including, also, the emotional climate during treatment, at home, and at work; (9) full coöperation of the patient and his family and associates; and (10) continuous follow-up.

To-day, more than ever before, medicine and psychiatry are working with the problem of alcoholism, but we have only touched the surface.

Because of alcoholism's widespread, insidious encroachment in all spheres of life, and its destructive effects on the family and the community, the medical profession and allied sciences must attack the problem in its early stages.

Moreover, they should strongly support community programs, educational courses, and church activities, giving to them the solidarity of medical backing and guidance as an aid in prevention.

We shall accomplish little—in spite of all our vaunted knowledge, in spite of recent conferences sponsored by industrial and medical groups, and in spite of the personal experience of every individual who has had an alcoholic in his family, or perhaps has been an alcoholic himself, or who knows an alcoholic who was "cured"—unless we keep firmly

in mind the fact that this psycho-socio-biological illness is comparable visually to tumors, including cancer.

And, finally, I would like to suggest that it might be wise to keep in mind the fact that alcohol is not as inert a substance as water and, when taken internally, may in some instances act as a sedative or a hypnotic, as an analgesic or a narcotic or a temporary anæsthetic, and in some cases as a permanent anæsthetic, causing death.

## GROUP PREMARITAL COUNSELING

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IN the volume, *The Practice of Group Therapy*, Dr. J. H. W. van Ophuijsen states, "As almost all forms of therapy, Group Therapy will in the future make its contribution to the prevention of disorders in addition to its usefulness as a method of treatment."<sup>1</sup> This preventive use of group work has already been put into effect in the development of a group premarital counseling service at the Mothers' Health Center in Brooklyn.

The patients in planned-parenthood centers have always come primarily for help in child spacing. The nature of the child-spacing service and the contraceptive methods prescribed favor the securing of individual medical and sexual histories from each patient. This discussion often serves as an impetus to the patient to bring up her sexual problems. Very often it is found that a woman has come for the service in the hope that a proper contraceptive will solve sexual difficulties. Others have assumed that their problems were physical in origin and have expected that the pelvic examination would reveal abnormalities that would explain their lack of sexual gratification. The realization that there is nothing organically wrong often makes it possible for them to begin to consider, for the first time, whether the problem might not be caused by other factors. The child-spacing service provides a natural setting in which a woman can discuss her intimate sexual relations within the framework of a service that is acceptable to her. In this setting patients naturally focus on the sexual area in their discussion, and

<sup>1</sup> *The Practice of Group Therapy*, edited by S. R. Slavson. New York: International Universities Press, 1948. Chap. 13, p. 263.

at times it is found that this is the major source of difficulty in their marriage.

When patients first raised these problems, they were referred to family agencies and other community resources for help. It was found, in most cases, that they were not ready for this, since they saw their problems as specifically and narrowly defined. Some wanted only information and others an opportunity for a more thorough discussion with some one at the center.

In 1946 a marriage-counseling service was inaugurated at the Mothers' Health Center in Brooklyn. This service was begun on an exploratory basis to determine the rôle of the planned-parenthood center in this field. Although it had been anticipated that most of the patients would require intensive therapy, experience showed that many of them were helped considerably by a type of short-term treatment in which correction of misinformation and the imparting of correct factual information were combined with an opportunity for the patient to be made aware of and to express her fears, ignorance, and destructive sexual attitudes. Such help was effective when patients could receive reassurance as to their physical normality, some basic knowledge about their sexual functions, and the opportunity to discuss freely their feelings and attitudes about sex.

Often, one or two of these interviews was found to be all that the patient actually wanted, and a follow-up revealed that real changes in functioning had occurred. The fact that the marriage counselor was a person whose attitudes toward sex were healthier and sounder than those they had known before usually made it possible for patients to release and to accept their own sexual feelings. Those patients who showed deep-seated personality problems and involved marital conflicts were helped to recognize them and were then referred to psychiatric clinics and family agencies.

Our experience convinced us that a fair proportion of sexual problems are due to lack of information, misinformation, and incorrect attitudes. In conformity with the newer emphasis on prevention, a premarital service, for engaged couples, including both individual and group therapy, was planned and initiated in the spring of 1947. This paper

will discuss our experience with these premarital groups. Since group therapy is a new technique in the field of premarital counseling, our approach was initially experimental.

Often a group service is developed because of shortages of personnel that make it impossible to offer individual service. This was not the reason for the group program at the center. Our groups were developed with the realization that the group in itself has certain values that make it an unusually good method for this type of service. In a group, differences are minimized—each couple can see that other people have experienced difficulties very similar to theirs. A feeling of group belonging can develop that may help the partners to accept themselves more easily.

Secondly, through the group the engaged couple can learn to talk together about ideas previously suppressed. Our experience in marriage counseling had shown that most patients did not feel free to discuss their sexual attitudes with their mates, and that many were even too inhibited to reveal to each other just what gave them pleasure in sexual relations. It was, therefore, recognized that such a sharing in this area was an even more difficult step for unmarried couples to take. The group setting could help them by its very permissiveness and by the example set by the therapist and by other young couples in the group. The third value in this approach is that it provides an opportunity for young couples to learn from one another. One person will feel free to ask a question that another could not. Fixed attitudes can be broken down when other points of view are expressed.

There was some question at first as to whether it would be wise to have groups that included both women and men. Would the girls in the premarital group feel too shy to raise questions particularly related to women if the men were present? We thought that the great advantage in seeing the couples together is that they both receive the same information at the same time and in the same way and have the opportunity to learn about one another. It was, therefore, decided to set up our groups to include only couples.

In order to begin the service, it was necessary to reach some engaged couples. The project was explained to the Brooklyn representative of the Jewish Welfare Board, who

felt that this kind of service would be of real interest to the young people who come to the community centers in Brooklyn. He, therefore, agreed to publicize the service in several centers. As a result of his activities, we secured a list of ten couples and letters were sent to them. Of these, two couples registered for the first series. We have had eight groups, ranging in size from two to six couples. They have included Negro and white, Protestant, Jewish, and Catholic young people, ranging in age from eighteen to thirty-two years of age. A total of twenty-seven couples have been seen in the groups. Sources of reference have been quite varied. Fourteen couples were referred by their friends who had taken the course; one by a minister; four from community contacts; three as a result of a letter asking general information.

We have found that the optimum number in a group is four couples. Beyond that it becomes difficult to individualize sufficiently. We have observed further that a shyer, more inhibited person seems to find it easier to talk in a small group.

This project has now been going on for over a year and a half and has been incorporated into the regular program of the center. We had hoped that we could plan the groups on some basis such as age and education of the individuals, but found that most of our applicants come in just before a group is to begin and within a few weeks of their marriage date. Accordingly, our groups were arranged on the simple basis of the fact that the couples are engaged and plan to be married shortly. We have since discovered that mixed cultural and educational groups have much value because of the differences expressed by various couples. Individuals are thus exposed to new points of view within the group. We have no intake interview, but ask each couple to fill out a simple application form which gives us material on age, education, and present occupation.

The content of the series was planned on the dynamic concepts that people marry to satisfy certain basic needs—love, sex, and parenthood—and that these needs are influenced by early childhood experiences, by social and cultural forces which either reinforce positive attitudes and values or pro-

duce negative ones. The lack of information, the misinformation, the fears and anxieties developed from the prohibition of normal release of the sexual need, the difficulties resulting from inadequate parent-child relationships—all adversely affect the capacity to love and prevent the development of a mature personality, culminating in difficulties in the marital adjustment.

It was anticipated that the presentation of these concepts would inculcate more positive attitudes and would help to develop insight into what these young people, as individuals, are bringing to their marriage and what the marital relationship involves.

We planned a series of three sessions, to deal, respectively, with love, sex, and parenthood. It has since been recognized that this is a satisfactory amount of time in which to cover the material and to insure full discussion. Each meeting usually lasts from three to three and a half hours.

We recognized that most of the young people who came to us would be interested primarily in more information about their sexuality. Our approach was to treat sexual adjustment in marriage as part of a total emotional relationship. In our first session we planned to consider what is involved when two people begin a life together. This would require the discussion of personality development and the influence of early experiences in the life of the individual. Such consideration is necessary to help a couple see that marriage alone does not bring about basic personality changes. A discussion of the development of a mature love relationship and its important rôle in marriage follows from this.

As we anticipated, the entire question as to how much one changes in making a good marital adjustment, and on what level these changes occur, was of great interest to most of our groups. We accepted the fact that these people were being married very soon and, therefore, did not focus on the question of choosing a mate. Rather, emphasis was placed on helping the partners in the approaching marriage see the ways in which they would be adjusting to each other.

Our next session involved discussion of psycho-sexual development, touching on sexual curiosity in the young child,

the usual kinds of prohibition he meets, the attitudes toward masturbation, and the changes and development that come about during puberty. Our aim was to help the group understand the prohibitions that society has placed upon them all their lives, and the fact that the inhibitions they have developed are not automatically shed when a religious or legal ceremony has been performed. This makes it possible for the group to consider their rôle in marriage as something that will take a period of time for them to work out to their greatest satisfaction, and is of help to those young people who have read several books on sex, have high expectations for themselves, and are full of anxiety that they will not be able to perform adequately.

The third session continued this discussion and then considered further sexual anatomy, physiology, the nature of the sexual act, differences in responses between men and women, and the question of family planning and contraception.

The method included a short presentation of basic material by the therapist and full discussion around this by members of the group. Experience has shown that this material is of vital interest to young people about to be married. The following excerpts will indicate some of the problems raised and the nature of group discussion around it:

"During a discussion of parent-child relationships, one of the group asked whether it was bad for parents to argue in front of children. It was pointed out that arguments have a profound effect upon children. To a child, a quarrel is like a battle. He does not want to take sides, but this battle tears him apart. A child is sensitive and this can have a marked effect on his feelings.

"Jack asked, rather hesitantly, what a child should do if he has been held back by his parents. Must he give in or can he break away? The therapist discussed in general terms the kinds of conflict that are precipitated in children when parents hang on to the children and do not leave them free to grow up and away. Actually, the parents should help the children cut the bond, so that they can become free, mature individuals. However, if the parent, for reasons of his own, cannot do this, then the children must be the ones to cut the bond, even though it is difficult for them.

"Jack then said that his mother treats him like a baby, has always treated him that way. Sylvia, his fiancée, remarked that her parents have never interfered and Jack confirmed this and added that he is happier with Sylvia's parents than he is at home. He revealed considerable conflict about his desire to break away from his mother's control and his fear of hurting her. He pointed out that all his brothers

had the same problem. Another member of the group said that a mother has no right to make her children feel bad and to 'throw up' to them all that she has done for them. Holding on to her children is bad for them and bad for her. Helen, one of the other girls, said it is better for the children to be open about it and not to give in to their mother and feel resentful underneath. Jack said that he could see that. His brothers had the same trouble and everything was all right on the surface, but underneath they were resentful and their wives were resentful. The therapist pointed out that this kind of suppressed resentment may affect them in many ways, even physically. Jack said that Sylvia had been telling him some of these things and he had begun to see his feelings differently. Sylvia added that she hadn't wanted to say too much about his mother hanging on to him because she was afraid that she would be considered a bad daughter-in-law."

Jack felt that he was helped considerably by this and later discussions about this problem. He did not feel that he needed any individual help, although this was always available. The follow-up sessions, six months after their marriage, revealed that Jack was handling the situation with his mother very well. He and Sylvia were living with her mother, who had always represented to him the desirable type of parent who could accept her children as adults. As a result of discussion and with the example of a good mother figure, he could release himself from his own mother without too much guilt.

Concern about masturbatory experiences was expressed as a basic problem in all groups. During a discussion of psychosexual development, one group participated as follows:

"Mary said that she had never heard the word masturbation until she had read it recently. The other three girls said they had no sexual feeling or desires that they remembered until they were engaged. Ellen said she had overheard boys talking about their masturbating in order to arouse themselves. She had been frankly shocked. Arnold said he had masturbated by himself and with a group of boys, but he felt guilty about it, as he was sure his family would disapprove. Robert said if you were told it was wrong, then you would feel that what you were doing was wrong. Ellen had watched a man masturbate until he ejaculated, and said that his wife was in the room with him, but not near him. She couldn't understand why any one should do that. This was discussed. Then Robert said many men would masturbate for the first orgasm and then they could take a long time to stimulate the woman and not have trouble holding themselves back. Arnold said that in the army boys would get into trouble if they were caught masturbating, but Robert felt there were always ways of not being found out."

With most of them, masturbation was associated with feelings of guilt, and there seemed to be very great relief, not only because of acceptance of this by the therapist, but also because of the realization that each was not alone in having done something that had been considered so shameful.

After a presentation of some basic concepts about personality growth and development, with emphasis on the importance of being able really to accept another person for what he or she is, the following problem was raised:

"Jean wondered where the dividing line was between 'wanting and can't.' She just can't do some things, although she feels that if she tried, she might like it. Larry, Jean's fiancé, feels if he gives in to Jean's wishes, either because he wants to or because he has to, he expects her to give in to him on some other points. Jean said she just could not and Larry would get angry and leave. The therapist said that often a person, seemingly perverse, couldn't accept certain things.

"Jean then told something of her background. She has always been babied and has had her own way, and she resents any criticism of herself. She feels very close to her mother. She admits to being spoiled, but likes getting her own way. At this point she saw no reason to try to modify her feelings and desires. Larry feels that he is more experienced and knows more and that, therefore, she should listen to him.

"Jean said another thing that bothered her was that Larry was always trying to kiss her in public. She objects, as she thinks it doesn't look nice. She feels she is cheapening herself and behaving like a pick-up. Larry could wait five minutes more until they are alone. Larry says she is stubborn, but he is, too. He would like to change and compromise, but he can't always do so. He believes there is no democracy in marriage. A woman plays on a man's sympathy until she gets her own way. He said teamwork in the army got things done, and he feels that his marriage will be successful if they practice teamwork."

The kinds of question raised by members of our groups illustrate the lack of factual material, as well as the actual distortions, in the sex information that they had had. Every group expressed much concern about their forthcoming sex experience. Gory stories that they had heard about the wedding-night experiences of their friends and relatives were repeated. There was found to be a general preoccupation with so-called "abnormal" sex practices. No couple dared to be different in sexual behavior. We were asked for norms. Such questions came up as: "How often should a couple have intercourse?" "What is the accepted position?" "What are perversions?" In most instances, dis-

cussion revealed that these young people were not fully released to accept and act on their own feelings and sexual desires. They did gain some realization that each couple has to work out its own individual adjustment, and that practices vary from couple to couple.

As we discussed sexual anatomy and physiology, using charts and models, both the men and the women showed that they had little conscious knowledge about their own bodies. They were interested in knowing about the structure and function of the male organ, as well as the entire female reproductive system. This led to further questions: "What is meant by foreplay?" "What is an orgasm?" "Can pregnancy occur if a woman does not have an orgasm?" "What does it mean to be over-sexed?"

All the time-worn taboos associated with menstruation were also brought out in discussion: "Is the blood bad blood?" "Is it all right to bathe?" "Doesn't intercourse during menstruation produce venereal disease?" This tied up closely with concern about fertility: "How does conception take place?" "Is it possible for a woman to become pregnant during the first six months of marriage?" "When is a woman most fertile?" "How is a baby born?"

Many fears were expressed about contraceptive methods; mainly, "Is it harmful?" "Can it cause cancer?" "Does contraception make a couple sterile?" As their questions were answered, they thought ahead and began to talk about sex education for their children. They wanted to develop better attitudes in their children than had been developed in them.

During the sessions in which the emphasis was placed on personality adjustment, many problems were discussed. Most common were concerns about personality clashes; the problem of getting along with in-laws; and the kinds of adjustment that have to be made when several families share living quarters. Questions about the handling of money were also frequent. Emphasis throughout was placed on the need for the couple to understand and to accept each other, to talk things out, and to face issues together.

As the service became known in the community, we received many last-minute requests from couples who were being mar-

ried either the following day or within the week. Obviously, they could not be absorbed into the group and were, therefore, seen individually. All of our couples were given a choice of group or individual sessions. Those who had enough time to come to the group invariably chose this. In addition, members of the groups have come in to see us individually, either prior to or after their marriage, to discuss very special problems that were not of common concern to the group. For example, one girl was concerned about leaving her sick mother, and wanted help in making plans for her. We referred her to a family agency for this. Another couple wanted to discuss their feelings about the fact that the girl had been adopted when a small child. After marriage, a few members of the group have come in to talk about their sexual adjustment as well as about conflict over the use of contraceptives. The fact that this had been discussed in one group session made this contact possible.

One follow-up group session, to evaluate the project, was held. Three couples, who had been married for more than six months, came to this meeting. There was amazingly free discussion of all aspects of their marital adjustments. Two couples had achieved satisfactory sexual relationships and were taking their other problems in stride. The other couple was experiencing conflict in practically all areas of their relationship. This couple had struggled with each other in the premarital group, and at that time we had anticipated a difficult process of adjustment. The other members of the group were able to see some of the basic problems that this couple were facing and were helpful in their discussion of the ways in which they themselves had handled similar problems. They could see that the problems themselves were not too different; it was the individual's attitude that made them serious in one case and minor in the other. All three couples expressed the conviction that the premarital sessions had helped them, not only in the factual material they had received, but also because they had come to see that a marriage has to develop.

A significant observation from these discussions is that so many young people choose their mates and set the dates of their marriages so inadequately prepared. At the end of

one of the series, one of the young men said, "Wouldn't it have been a good idea for us to have had these talks before we became engaged?" The implication was plain that better information and orientation at an earlier age might lead a young person to take into account different considerations in his choice of a mate.

In conclusion, we can say that premarital group therapy can be a positive contribution to the prevention of marital maladjustments. It can help young people to develop more positive attitudes toward marriage, both through increased awareness of the meaning of interpersonal relationships and because of the knowledge of what each one brings to marriage and what can be expected from marriage. The basic factual information that is given can help correct misinformation and thus clear the way for healthier attitudes. The fact that couples are seen together in a group makes it possible for each couple to accept the information together. The group session acts as a stimulus for them to talk to each other about problems and helps them in their interpersonal communication.

The group also stresses the basic needs of all people, and so helps to develop an awareness of the sameness of all. This makes possible a lessened feeling of isolation and at the same time increases awareness of the uniqueness of each individual as a result of his heritage and life experiences. The group process makes possible the more rapid release of fears, anxieties, and guilt, and helps bring out specific conflicts, some of which can be resolved immediately through the group. Other, more deeply rooted difficulties are at times revealed, and the need for additional help is more readily accepted because of the group support.

Our experience with this form of therapy has been most gratifying because of the potentialities it has revealed for preventive work in the ever-growing field of marital adjustment.

## A CHILD-GUIDANCE CLINIC AS A NUCLEUS FOR COMMUNITY EDUCATION \*

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CHILD-GUIDANCE clinics, like health centers, have a two-fold function to perform. They are centers not only for the treatment of illnesses, but for the dissemination of information directed toward the prevention of illness.

Child-guidance clinics are set up primarily to examine and to treat children with behavior difficulties and to provide consultative services to persons and agencies concerned with the children referred to them, but a clinic serves the community best if a goodly portion of its time and efforts are expended on education in the methods of preventing the development of children's problems.

With this purpose in view, the staff members of many such clinics accept invitations from parent-teacher associations, church groups, and other civic organizations to give talks on child welfare. The value of such lectures, however, is often very limited and sometimes doubtful, because the speaker is rarely sure how much the listener has absorbed, or how he has associated what he has heard with his own experience. It is disconcerting to discover what distorted ideas people sometimes get from such lectures. For these talks to have meaning for the listeners, some preliminary preparation should be given to them.

In our work we have found that a series of small discussion groups in which the members participate in conducting the meetings has brought very satisfactory results. Most people who attend large general gatherings in which emotional problems are discussed are prone to think immediately

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of neighbors or friends to whom the discussion might apply, but seldom realize that it might apply to themselves. While there is no doubt some value in giving people an understanding of their neighbors' emotional reactions, much more can be accomplished through the education of the individual listener than through the more indirect method of approach. A skilled professional leader can, in a small discussion group, stimulate each individual member to give consideration to his own particular problem, or problems, and encourage him to speak up in discussion and to ask questions.

In several rural and urban areas we tried out this plan with mothers of pre-school children and children in the grades. Each group consisted of from six to sixteen mothers. In the first meeting with a group, the professional leader gave a short introductory talk about the purpose of the meeting and then encouraged the mothers to talk about their own daily problems with their children. It might seem that mothers would hesitate to expose themselves and their children to a group discussion, but the opposite proved to be true. In none of our groups did we find a single member who hesitated to bring up questions involving her problems in connection with her children. These questions were usually followed by excellent discussions in which every member participated. The discussions led to still further questions, so that we never ran out of material. The participants would have liked to extend the number of meetings indefinitely, but the professional staff had only so much time to spend in this work, and the number of meetings had, therefore, to be limited to six for each group.

The professional person who conducted the meeting formulated her answers in such a way that the members of the group could gain a definite understanding of her meaning and grasp the significance of the point she was making. The informal nature of the gathering made it possible for any member at any time to ask for clarification of any of the material that she did not understand, and all matters were discussed thoroughly to clear up any misconceptions or misinterpretations.

Several of these mothers' groups asked if a fathers' group could be formed, too, since they had talked over with their

husbands the matters considered in our meetings and the fathers also wanted the privilege of group meetings.

A nearby radio station asked to broadcast one of our mothers' meetings. We did not know how the members would feel about discussing their problems over the radio, but to our astonishment nearly every one volunteered for this experiment.

From these various experiments with mothers, we learned that parents are usually very willing to discuss in a group such delicate matters as parent-child relationships if the professional leader is skilled in handling such matters. In fact, in many instances, mothers were glad to have an opportunity to discuss not only their children's difficulties, but also their troubles with mother-in-laws, grandparents, and so on. A good many of these mothers asked for personal interviews in the clinic.

Teachers formed another group. Next to the home, the school is the most important place in which to attack children's problems early in their development. By educating teachers in these matters and giving them an understanding of children's emotional development and reactions, it is possible to aid the teacher not only to help the child, but also to help herself. Here, again, we met with a small number—twelve to fifteen—and after introducing the purpose of the meeting, the leader asked the teachers to present cases of children in their classrooms who seemed to have behavior difficulties.

The teachers in this community felt that they derived so much benefit from these meetings and considered the training they received such an important tool for use in their work that they asked for an accredited course in the field, and as a result of this request one of the state teachers colleges accredited the course on an experimental basis.

These teachers not only learned much about the dynamics of personality, but many of them became very useful to us in therapy. Distance, lack of time, and other factors sometimes made it impossible for us to give treatment to many of the children in the clinic, and this plan for using teachers as therapists, which was first forced upon us by necessity, gradually proved one of our most useful assets. In these cases the clinic staff always functioned as consultant and

supervisor, and follow-up discussions between teacher and clinic were held at regular intervals. Here, again, cases which came up in the group discussions were frequently brought to the clinic for individual study if that seemed indicated.

One of the most interesting discussion groups with whom we met were the clergymen in the community who had asked that a class or seminar similar to the one for teachers be formed for them. Not long after the group was organized, a scandal broke out in one of our communities, involving the youngsters in about thirty families. It was gratifying indeed to see how many of the clergymen went to work to help these families by applying the principles they had learned in our meetings.

Judges, police, and probation officers formed a group that was very much interested in discussing problems of delinquency. The close coöperation of this group with the child-guidance clinic has brought about splendid results in helping delinquent children and saving them from correctional institutions. Since juvenile delinquency has been such a popular subject for newspapers and other publications, this teamwork has proved to be a very valuable force in approaching the problem of juvenile delinquency and in dispelling many of the erroneous and distorted ideas some people have obtained from their reading.

As a result of all this community education, it was possible to form a very good working relationship with the press. The sensational way in which many juvenile crimes are presented in the newspapers creates much confusion and misunderstanding in the minds of our citizens, and does more harm than good. We have found that by taking time to discuss with press representatives the dynamic factors involved in juvenile problems, we can give them our viewpoint so that they can express their ideas in a way much more beneficial to their readers than by printing merely sensational news. After all, the newspapers are important educators of our nation and, therefore, have a serious responsibility.

Coöperation and teamwork between social agencies and the child-guidance clinic is probably the factor next in importance to the school in getting action in the therapy of a case. Our

staff meets with representatives of social agencies at least once a month. The clinic has to limit its activities in behalf of the children referred to it for child study and treatment; the field work, placement, selection of foster homes, adoption, and often the treatment of the parents fall to the lot of the social agencies. It is not uncommon to find that the same case has been studied by several agencies, but without a complete exchange of all their findings, so that the poor client has been confused and discouraged by all the studies that have been made without anything being done. Also, much time is wasted through this overlapping of activities. Through informal discussions with the various members of these agencies, including representatives of the state welfare department, the courts, the police, the county and city nurses, the Y. M. C. A., the Red Cross, and tuberculosis and mental institutions, much understanding has been gained about the necessity for teamwork and the exchange of ideas and experiences, and a much smoother functioning of all our work has been brought about. Much time has been gained by the cutting of red tape through the coöperation of these agencies.

With social agencies we discuss fully the factors involved in foster-home placement, adoption, and the institutionalization of children, since so often problems arise because children have been improperly placed. It is easy to blame an agency, just as it is easy to blame parents, but nothing constructive is accomplished by such an attitude. It is much more important to educate them, to teach them, and our experience has convinced us that the great majority of people are eager to coöperate and really want to learn.

Last, but not least, of our forces for community education is the citizens' committee which sponsors our clinic. We sought the formation of this group in order to have persons representing the various professions and interests of the community to aid us in putting across our program of education. It was amazing to us to see with what enthusiasm and interest these people, for the most part untrained in psychiatric and psychological concepts, plunged into our work to make valuable contributions to it and to give us invaluable suggestions. One member suggested an intensive study of the problem presented by comic strips and comic books. Another suggested the formation of small groups

of parents of delinquents for the discussion of their particular problems. Perhaps the finest symbol of their interest and enthusiasm has been the providing of proper housing for our clinic and the complete remodeling of the building to suit our particular needs. This undertaking aroused in the community a pride in providing and maintaining a dignified educational center for work with children.

Except for the purely intramural problems which require staff decision, all other questions are decided by the citizens' committee. When this committee was first formed, the members asked that a training program be arranged for them that would give them a good understanding of the dynamics of children's and adults' personality problems.

All these training programs and discussion groups have brought to the community an awareness of children's problems—what they involve—and a desire to do something about them, so that we receive coöperation and assistance from all sides. Through this help we have been able to build up a much more effective preventive program than we could have done merely by examining and treating individual cases in the clinic. To an increasing degree the citizens of our community call at the clinic and ask for interviews to discuss particular problems.

Although our work is still in the experimental stage, we have reason to believe that it will lead eventually to a penetration, into the individual families in the community, of ideas and ideals of prevention in regard to children's problems. We consider this goal the *raison d'être* of a child-guidance clinic.

## THE SCOPE AND FUNCTION OF EUTHENICS

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THE purpose of this paper is to stress the significance of scientific terminology in the organization of research and service in human welfare. Sciences and arts take shape as they gradually organize their constituencies around a common frame of reference. When I studied physics sixty years ago, the textbook, written by one of Yale's foremost scientists of that day, bore the title, *Natural Philosophy*; but physics has become a specific frame of reference for its logical subdivisions, with assignments to correlated fields for pure and applied physics, and is no longer a philosophy. My first appointment in psychology listed me as assistant professor of philosophy; but psychology is now out under its own frame of reference as a genus for the spiraling list of species and varieties in fields of operation. When I began to advocate a scientific approach to aesthetics, I was confronted with armchair philosophers who scoffed at the attempt to make a scientific approach to this esoteric domain; but now aesthetics is being redefined in a scientific spirit. Everywhere the movement is from unanalyzed wholes to more and more systematically defined and systematized frames of reference. Euthenics has followed that pattern.

The term eugenics, meaning well born, is a well-established concept, denoting those aspects of all sciences and arts which have a bearing on improvement of the individual or the group through the medium of the germ cell. The companion piece, euthenics, denotes those aspects of all sciences and arts which have a bearing on the improvement of the individual or the group through the medium of the objective or the subjective environment. The one has to do with heredity; the other, with the environment. Both are adequate carry-alls or clearing houses for a vastly expanding group of approaches to betterment or welfare. The term euthenics is derived from

the Greek word, *euthenia*, which means well-being, and may be defined generally as the science and art of welfare. It has found approval and implementation in anthropology, genetics, comparative psychology, child welfare, and race betterment, and has found some recognition in the fields of social, educational, and medical welfare.

As a frame of reference, euthenics faces a responsibility for definition and classification within its domain. But there are no static definitions or classifications in science or art. They must be dynamic, flexible, and tentative as working hypotheses, in step with progress toward new data, new resources, new functions, new insights, and new relationships.

Ultimately, euthenics must be described and explained in terms of biological principles of organic life. Such a principle may be found in some biological concept such as the law of homeostasis which may determine the limits of capacity and safety within which, with the mode as a base, we may express deviations in one direction noxious and in the other direction beneficent for the organism. The elaboration of such theoretical organization for research and service must bide its time; but progress is being made in foundation work in such fields as nutrition, sanitation, education, and psychosomatic medicine. In the meantime, we must proceed by trial and error to build a practical design for happy, safe, and wise living.

The greatest urgency now is to find a place for euthenics in our systems of education. I have recently outlined a capstone course for the senior year in our secondary schools in which the youth proceed for a year in a student-centered project course to bring together all the fragments of welfare efforts in these schools into a single unified survey of euthenics in practice.<sup>1</sup>

Psychologists are now responsible for presenting the case for euthenics after progressive surveys of the issues, needs, and opportunities for systematized welfare. In this they are baffled by countless incoherent projects upon the horizon. They realize, however, that not long ago botany, zoölogy, anthropology, medicine, and engineering faced the same kind of frustration. Botany yielded to systematic description and

<sup>1</sup> See "Euthenics, A Design for Living," by Carl E. Seashore. *The Educational Forum*, Vol. 12, pp. 149-55, January, 1948.

classification and is now a basic frame of reference for every phase of plant life, with an intricate system of coördinated plant sciences. In the same manner euthenics pursues the organization of the welfare sciences, arts, and technologies for welfare. It stands not only with the material sciences, but also with the normative sciences such as mathematics, eugenics, ethics, and economics as a carry-all which serves as a clearing house within its domain. The situation of euthenics is analogous to the situation of electronics. The frame of reference in electronics is electricity; in euthenics it is welfare.

A century ago scientists laughed at anthropology for claiming as its domain all the sciences that deal with man. But anthropology made good its claim and came in on the ground floor as one of the seven divisions of science in the establishment of the National Academy. When, at the end of World War I, psychology was to be admitted to the National Research Council, the working branch of the National Academy, it was necessary to unite with one of the existing divisions, and psychologists were given the choice of uniting with anthropology or agriculture. The psychologists chose to unite with anthropology, which emphasizes the historical approach to man, rather than with agriculture, which was at that time a carry-all for the biological sciences in the academy. But the decision was not so drastic as it may seem because psychology continued to work as a biological science and has as its main content the science of man. Now, however, at the close of World War II, in which psychology demonstrated a great vitality, psychology has been set up as a separate division in the academy. Is it not within the bounds of reason that euthenics, which is now under the protectorate of psychology, may loom up as coördinate with psychology or even as a separate division in the highest learned society in America? That prospect looks encouraging in the light of current movements in Congress.

The general function of euthenics is to organize and supervise all welfare interests and activities by comprehensive classification and blueprints for projects in welfare. The issues, needs, techniques, and theories in welfare fall into orderly genera, species, and varieties biologically. This organization leads to integration with related and under-

lying sciences and arts. That in turn leads to coöperation and comradeship in the division of labor and the conduct of research and service—to economies in the utilization of history and theories of welfare, of a common storehouse of knowledge and resources; to countless economies in such fields as publication, legislation, and the establishment of welfare institutions; to the filling in of gaps in knowledge; and to the unification of global enterprises—in short, to a joint science and service for welfare, both human and animal.

We need only mention here some of the recognized areas of coverage. Euthenics is a science and an art, united in a technology. As a technology, it draws upon pure science for the stock of verified knowledge; surveys the evolution and development in theory and practice; predicts the most reliable trends and hypotheses for welfare; maintains a critique of scientific standards and economies in welfare; and recognizes the fact that when a practical issue is verified, it is gradually accepted as common sense. As an art, euthenics has the same coverage as the science.

Individual psychology and social psychology have too long functioned as isolated areas. In its formative period, psychology took the individual point of view in the interest of rigorous control for laboratory experiments in pure science. The same is true of euthenics, except in the earliest manifestation in the movement for race betterment. But we now recognize that experiments on the individual must take into account the total individual in his total social and environmental situation, and social experiments must involve an inventory of the kinds of individual in the group.

Likewise, curative welfare and preventive welfare have too long been segregated. Curative medicine is short-range action in emergency. Throughout the ages medical practice has concentrated upon this service. Preventive medicine is just coming in, and the same is true of preventive practice in euthenics. "An ounce of prevention is worth a pound of cure," has been a dead letter, but to-day euthenics is reasserting the wisdom of the old adage. While welfare workers must still have clinics for emergencies, the euthenic program is set primarily for the normal and healthy individual. Improvement of the normal child, for example, is a major

scientific goal in child welfare; but in practice that must go hand in hand with corrective and remedial measures.

We need only mention some of the services that call for aid from euthenists. Psychosomatic hygiene is now crying out for a check list of problems and techniques that can be worked out by euthenists. Nutrition, rest, exercise, peace of mind, and philosophy of life call for well-oriented principles. Morals are reoriented in part from a utilitarian point of view. Religion now places major emphasis on how to live well in this world. Euthenics now challenges education to change human nature. Criminology is reforming its theories and institutions scientifically. Vocational and avocational guidance are now reoriented, not only for sound guidance, but as a method of learning. Legislation, literature, art, and philosophy are becoming euthenic.

Euthenics is now operating from new vantage grounds by integrating age units. We have seen child-welfare movements, adolescence movements, and later-maturity movements come and go as if they had nothing in common. Euthenics calls for reorientation and coöperation throughout the age levels on the basis of common genetic principles in biophysics, mental growth, and the interpretation of racial evolution.

The euthenic movement is enhanced by the fact that science and art are among the most potent agencies for world understanding and good will. The problem of peace is largely how to keep the people of the earth alive, happy, successful, and good. Euthenics can now say: Keep each individual busy at his highest natural level of successful achievement and he will be happy, useful, and good. Such a principle may be both for foreign and for home consumption.

The promotion of euthenics is particularly timely now when the voice of America is demanding a seat in the cabinet through the establishment of a department of human welfare, which might logically be called "The Department of Euthenics."

## MENTAL DISEASES AMONG THE AGED IN NEW YORK STATE

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MENTAL diseases vary in their relative distributions at different periods of the life span. In early years, there is a predominance of dementia præcox and of manic-depressive psychoses. These groups rise to their maximum intensities in the late thirties and in the forties. They are largely succeeded in the next ten years by general paresis and the alcoholic psychoses. In the sixties, psychoses with cerebral arteriosclerosis and senile psychoses begin to predominate, and these groups increase steadily until the end of the life span. The senile psychoses are naturally the most prevalent after the age of 75. The combination of these groups into the single category of mental disease results in a trend of characteristic appearance.

The rate of first admissions with mental disease per 100,000 population of corresponding age is lowest in childhood. The rate rises rapidly through youth and early maturity, increases at a lesser rate through the involutional period, and then rises steadily and very rapidly through old age. It is clear, therefore, that although mental diseases strike at all ages, the probability of such a disease is far greater during old age than at any other period of life.

This trend is shown clearly in Table 1. During the three fiscal years ended March 31, 1941, there were 46,633 first admissions to all hospitals for mental disease in New York State. There were relatively few admissions under 15 years of age. The totals then rose rapidly to a maximum of 4,257 at 35-to-39 years of age, decreasing slowly thereafter to a minimum in old age. The average annual rates per 100,000 population at corresponding ages show a very different trend, however. They rise steadily from the youngest to the older ages. At 10-to-14 years, for example, there were only 8.71 first admissions per 100,000 population. The rates increased very rapidly to 127.56 per 100,000 population at ages 35 to

TABLE 1.—AGES OF FIRST ADMISSIONS TO ALL STATE AND LICENSED HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, FISCAL YEARS 1939-1941, AND AVERAGE ANNUAL RATES OF FIRST ADMISSIONS PER 100,000 POPULATION

Age (years)	Number			Percent			Average annual rate per 100,000 population		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Under 5 .....	7	5	12	*	*	*	0.54	0.41	0.48
5-9 .....	98	33	131	0.4	0.1	0.3	7.17	2.51	4.89
10-14 .....	171	102	273	0.7	0.5	0.6	10.77	6.60	8.71
15-19 .....	1,013	849	1,862	4.1	3.8	4.0	60.06	50.51	55.29
20-24 .....	1,720	1,434	3,154	7.0	6.5	6.8	103.96	80.56	91.83
25-29 .....	1,854	1,901	3,755	7.6	8.6	8.1	111.22	102.91	106.85
30-34 .....	2,096	1,967	4,063	8.6	8.9	8.7	124.89	110.69	117.58
35-39 .....	2,924	2,033	4,957	9.1	9.2	9.1	134.20	121.01	127.56
40-44 .....	2,261	1,843	4,104	9.3	8.3	8.8	140.31	116.06	128.28
45-49 .....	2,160	1,897	4,057	8.8	8.5	8.7	144.67	132.86	138.89
50-54 .....	2,165	1,777	3,942	8.9	8.0	8.4	164.58	145.39	155.33
55-59 .....	1,724	1,430	3,154	7.1	6.4	6.8	172.61	149.32	161.21
60-64 .....	1,652	1,424	3,076	6.8	6.4	6.6	213.46	179.66	196.35
65-69 .....	1,592	1,494	3,086	6.5	6.7	6.6	282.50	240.27	260.35
70-74 .....	1,390	1,368	2,758	5.7	6.2	5.9	375.02	319.00	344.97
75 and over .....	2,304	2,645	4,949	9.4	11.9	10.6	679.26	603.30	636.44
Total .....	24,431	22,202	46,633	100.0	100.0	100.0	121.90	109.22	115.51

\* Less than 0.05.

39. The rates continued to increase, though slowly, reaching 161.21 per 100,000 population at 55-to-59 years. At higher ages, the rates grew very rapidly to a maximum in extreme old age.

It is well known that the population of the state of New York has been growing older. In 1920, those aged 60 or over included 7.7 per cent of the total population. In 1940, this age group included 10.7 per cent of the total population. First admissions have shown a similar trend. In 1920, first admissions aged 60 or over to all hospitals for mental disease in New York State included 17.8 per cent of the total first admissions. In 1930, this had increased to 22.1 per cent. In 1940, the group had increased further to 29.7 per cent.

The average age of first admissions to all state and licensed hospitals for mental disease in New York increased from 42.69 years in 1920 to 44.91 in 1930 and to 48.47 in 1940, an increase of 5.78 years in 20 years. The average ages of male and female first admissions increased by 6.38 and 5.12 years, respectively. We may consider, especially, such groups as psychoses with cerebral arteriosclerosis and senile psychoses, which are the primary old-age groups. In the former, the average age at first admission increased from 64.79 in 1920 to 67.74 in 1940. In the latter, the average age increased from 73.60 in 1920 to 76.92 in 1940.

Table 2 compares the average annual rates of first admissions in 1919-1921, 1929-1931, and 1939-1941. With two exceptions, the rate of first admissions increased significantly among males between 1919-1921 and 1929-1931 in all age groups. The greatest rates of increase occurred, however, at 70 years or over. Between 1929-1931 and 1939-1941, the average annual rates of first admissions again increased at all ages, with an exception at ages 35 to 39. Again the rate of increase was greatest at the advanced ages. Among females, there were no significant changes in rates of first admission between 1919-1921 and 1929-1931 until old age, where the rates increased by from 10 to 33 per cent. The rates of increase were more significant between 1929-1931 and 1939-1941, when all the rates increased very sensibly. But, again, the greatest rates of increase occurred at the advanced ages.

Thus, not only are annual rates of first admissions highest in old age, but these rates have been increasing more rapidly than at any other period of life.

### Females

Age (years)	1919-1921			1929-1931			1939-1941		
	(a)	(b)	(c)	(a)	(b)	(c)	(a)	(b)	(c)
15-19	54.01	57.80	60.06	1.04	1.07	1.04	40.36	38.68	50.51
20-24	108.74	100.72	103.96	1.03	0.93	1.03	66.67	67.53	80.86
25-29	120.64	103.00	111.22	1.08	0.85	1.08	95.62	84.86	102.91
30-34	114.49	124.52	124.89	1.00	1.09	1.00	100.51	97.09	110.69
35-39	120.77	142.12	134.20	0.94	1.10	0.94	106.74	102.15	121.01
40-44	113.10	136.13	140.31	1.03	1.20	1.03	107.97	114.26	116.06
45-49	108.14	134.47	144.67	1.08	1.24	1.08	121.88	107.59	132.86
50-54	106.04	140.25	164.58	1.10	1.41	1.10	125.56	119.39	145.39
55-59	118.32	150.27	172.61	1.14	1.27	1.14	120.79	121.52	149.32
60-64	139.66	180.48	213.46	1.18	1.29	1.18	134.76	134.01	179.66
65-69	178.57	220.34	282.50	1.23	1.23	1.28	149.04	176.26	240.27
70-74	190.08	316.75	375.02	1.18	1.61	1.18	208.37	228.54	319.00
75 and over	289.00	465.56	679.26	1.46	1.68	1.46	282.37	376.92	603.30

Rates of first admissions give the probability of a mental disease at a given age in a single year. A more significant measure, known as the expectation of mental disease, gives the probability at a given age of developing a mental disorder at any time after that age to the end of the life span. For example, the expectation of a mental disease at birth among males in New York State in 1920 was 48.2 per thousand. That is, 48.2 of every 1,000 males at birth would, according to the rates of first admissions and of general mortality in New York State in 1920, develop a mental disease before they died. In 1930, the corresponding expectation at birth was 63.9, an increase of 33 per cent. In 1940, the expectation had grown to 80.5, an increase during the decade of 26 per cent. Among females, the expectations of mental disease at birth in 1920, 1930, and 1940 were, respectively, 48.1, 55.8, and 82.0 per thousand. Between 1920 and 1930, the expectations at birth increased by 16 per cent. Between 1930 and 1940, they increased by 47 per cent. Between 1920 and 1940, there were increased expectations of mental disease at every age. But the rates of increase were all significantly greater at 60 years of age or over. These rates are summarized in Table 3.

Thus among males the expectation of mental disease at birth increased by 33 per cent between 1920 and 1930. But between age 60 and age 90, the expectations increased during the interval by from 37 to 96 per cent. Between 1930 and 1940, the expectations increased among males by 34 per cent at age 60, and 101 per cent at age 95, compared with an increase of only 26 per cent at birth.

Among females there were similar increases at the advanced ages. Thus, between 1920 and 1930, the expectation of mental disease increased by 18 per cent at age 60, and 159 per cent at age 95, compared with 16 per cent at birth. Between 1930 and 1940, the expectation of mental disease increased by 58 per cent at age 60, and by 100 per cent or more toward the end of the life span, compared with an increase of only 47 per cent at birth.

The significance of the increase in mental disease at age 60 or over will be enhanced by a consideration of psychoses with cerebral arteriosclerosis, a disorder largely associated with advanced age.

## MENTAL HYGIENE

TABLE 3.—EXPECTATION OF MENTAL DISEASE\* IN NEW YORK STATE, 1920, 1930, AND 1940 †

Exact age (years)	Males						Females					
	1920			1930			1920			1930		
	(a)	(b)	(c)	(a)	(b)	(c)	(a)	(b)	(c)	(a)	(b)	(c)
0.....	48.2	63.9	80.5	1.33	1.26	1.47	48.1	55.8	82.0	1.16	1.47	1.58
60.....	28.4	38.8	51.9	1.37	1.34	1.58	28.5	33.7	55.3	1.18	1.58	1.60
65.....	26.3	37.3	50.6	1.42	1.36	1.60	26.0	32.1	51.2	1.23	1.60	1.63
70.....	23.8	36.3	49.8	1.53	1.37	1.63	24.3	30.4	49.5	1.25	1.63	1.68
75.....	21.6	34.0	49.7	1.57	1.46	1.68	22.1	28.9	48.5	1.31	1.68	1.73
80.....	20.6	30.0	46.9	1.46	1.56	1.73	20.3	26.2	45.4	1.29	1.73	1.89
85.....	17.1	26.5	42.5	1.54	1.60	1.89	16.4	22.2	41.9	1.35	1.89	1.98
90.....	12.2	23.9	39.4	1.96	1.64	2.01	13.0	20.7	40.9	1.59	1.98	2.59
95.....	.....	21.7	43.6	.....	2.01	.....	8.8	22.8	40.3	.....	2.59	1.77
100.....	.....	.....	39.2	.....	.....	.....	.....	13.0	32.0	.....	.....	2.46

\* Per 1,000 population at given age.

† Summarized from a chapter by Benjamin Malzberg in *Trends in Mental Disease*. New York: Kings Crown Press, 1945. p. 47.

TABLE 4.—EXPECTATION OF PSYCHOSES WITH CEREBRAL ARTERIOSCLEROSIS\* IN NEW YORK STATE, 1920, 1930, AND 1940†

Exact age (years)	Males						Females					
	1920			1930			1920			1930		
	(a)	(b)	(c)	(a)	(b)	(c)	(a)	(b)	(c)	(a)	(b)	(c)
0.....	51.2	113.9	191.6	2.22	1.68	c/b	37.4	95.4	186.3	b/a	2.55	c/b
60.....	83.2	172.6	262.9	2.07	1.52	1.89	49.7	119.8	226.1	2.41	1.89	1.89
65.....	75.3	168.6	256.6	2.24	1.52	1.89	41.6	111.5	210.5	2.68	1.89	1.89
70.....	56.3	157.3	234.3	2.79	1.49	1.90	34.8	97.0	184.7	2.79	1.90	1.90
75.....	44.9	135.2	206.0	3.01	1.52	1.87	28.6	82.6	154.2	2.89	1.87	1.87
80.....	33.9	103.5	160.5	3.05	1.55	1.76	18.0	59.9	105.6	3.33	1.76	1.76
85.....	26.7	68.8	129.7	2.58	1.89	2.05	13.7	37.9	77.8	2.77	2.05	2.05
90.....	28.6	40.1	125.0	1.40	3.12	2.31	12.6	21.7	50.1	1.72	2.31	2.31
95.....	.....	.....	129.3	.....	.....	.....	.....	.....	28.4	.....	.....	.....

\* Per 10,000 population at given age.

† Summarized from a study by Benjamin Malzberg. See *Psychiatric Quarterly*, Vol. 19, January, 1945. p. 130.

As shown in Table 4, in 1920, the expectation at birth among males of developing such a disease during a lifetime was 51.2 per 10,000. This grew to 113.9 in 1930, and to 191.6 in 1940. Between 1920 and 1930, the expectation at birth increased by 122 per cent. Between 1930 and 1940, it increased by 68 per cent. At ages 70 to 85, however, the expectation of such a psychosis increased by from 100 to 200 per cent between 1920 and 1930, and by from 50 to 90 per cent (and over) between 1930 and 1940.

Among females, the expectation of a psychosis with cerebral arteriosclerosis increased at birth by 155 per cent between 1920 and 1930, whereas it increased by amounts up to 233 per cent at the older ages. Among females, the expectation increased at all ages between 1930 and 1940, though the trend with age was not so marked as during the previous decade.

From these different lines of evidence we may draw the conclusion that mental disease is not only most frequent, relatively, among the aged, but that rates of mental disease have increased significantly among them since 1920. When it first became apparent that general rates of first admission were increasing, this was ascribed to the effect of the rise in the average age of the general population, and to increasing longevity. By making comparisons on the basis of a constant age distribution, however, it was shown that this is not a tenable explanation.<sup>1</sup> The writer, therefore, suggested the following possible explanation of the rising trend of mental disease among the aged:

"The upward trend in these disorders is probably associated with an increase in the degenerative diseases as a whole. The human organism must break down at some time. In younger persons, the organism is subject to one set of diseases, such as tuberculosis. The control of this disease in recent decades has extended the expectation of life, and consequently more people have reached that period of life at which circulatory and other degenerative diseases become manifest. A generation ago, those surviving to middle age probably constituted a better physical selection, on the whole, than those reaching the same age periods to-day. Consequently, in corresponding age periods, we now find greater morbidity and mortality from degenerative diseases. With these are associated the physical conditions that produce senility and cerebral arteriosclerosis. In brief, then, we find increasing rates of both senile and arteriosclerotic mental disorders, because the individuals constituting

<sup>1</sup> See "The Increase of Mental Disease," by Benjamin Malzberg. *Psychiatric Quarterly*, Vol. 17, July, 1943. p. 394.

the susceptible age groups to-day are probably not selected as rigorously as were the corresponding age groups of an earlier generation."<sup>1</sup>

*Some Characteristics of First Admissions, Aged 60 Years or Over.*—During the fiscal year ended March 31, 1948, there were, as shown in Table 5, 6,249 first admissions to the state and licensed hospitals for mental disease, aged 60 years or over, of whom 2,926, or 46.8 per cent, were males and 3,323, or 53.2 per cent, females. The sex difference is associated with the numerical excess of females in the general population at the older ages. Of the 6,249 first admissions, 5,697, or 91.2 per cent, were admitted to the civil state hospitals. Of the remainder, 513 were admitted to the private licensed hospitals. Ten were admitted to the two hospitals for the criminal insane in New York State, 23 to the two federal hospitals for mentally ill veterans, and 6 to the U. S. Marine Hospital. The fact that the vast majority are admitted to the civil state hospitals may be attributed, first, to the economic factor, and, second, to the fact that the private hospitals are not so likely to accept older and, presumably, chronic patients.

Of the 6,249 first admissions aged 60 years or over, 2,778, or 44.4 per cent, represented psychoses with cerebral arteriosclerosis, and 2,464, or 39.4 per cent, were senile psychoses. The involutional psychoses included 236, or 3.8 per cent. In contrast, the more significant of the remaining groups were as follows: general paresis, 90, or 1.4 per cent; alcoholic psychoses, 147, or 2.4 per cent; manic-depressive psychoses, 100, or 1.6 per cent; dementia præcox, 95, or 1.5 per cent. During the same years, there were 18,407 first admissions at all ages, of whom 5,052, or 27.4 per cent, were cases of dementia præcox. Psychoses with cerebral arteriosclerosis and senile psychoses represented only 17.3 and 13.4 per cent, respectively, of all first admissions, in contrast with 44.4 per cent and 39.4 per cent of the aged group.

*Environment.*—Table 6 shows the environmental distribution of the 6,249 first admissions aged 60 or over. Following the definitions of the United States Bureau of the Census, those communities with a population of 2,500 or over are considered urban. The others are classed as rural. Upon

<sup>1</sup> *Ibid.* p. 400.

TABLE 5.—FIRST ADMISSIONS TO ALL STATE AND LICENSED HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, AGED 60 YEARS OR OVER, YEAR ENDED MARCH 31, 1948

	Age (years)																		100 and Over
	Total			60-64		65-69		70-74		75-79		80-84		85-89		90-94		95-99	
	M.	F.	T.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.
<i>Mental disorders</i>	73	17	90	42	4	17	9	9	4	5	...	...	...	...	...	...	...	...	...
General paresis ...	6	1	7	3	1	1	...	2	...	...	...	...	...	...	...	...	...	...	...
With other syphilis of central nervous system	...	1	1	...	1	...	...	...	...	...	...	...	...	...	...	...	...	...	...
With epidemic encephalitis	...	1	1	...	1	...	...	...	...	...	...	...	...	...	...	...	...	...	...
With other infectious diseases	3	2	5	1	1	...	...	2	1	...	...	...	...	...	...	...	...	...	...
Alcoholic	120	27	147	65	11	37	9	13	6	5	1	...	...	...	...	...	...	...	...
Due to drugs or other exogenous poisons	2	2	4	1	...	1	...	...	2	...	...	...	...	...	...	...	...	...	...
Traumatic	19	3	22	9	...	4	1	4	1	1	...	...	...	1	...	...	...	...	...
With cerebral arteriosclerosis	1,496	1,282	2,778	280	229	358	282	348	321	280	246	136	126	76	60	15	14	2	4
With other disturbances of circulation	21	14	35	9	7	5	3	3	4	2	...	...	2	...	...	...	...	...	...
With convulsive disorders	10	10	20	4	4	4	4	2	1	...	1	...	...	...	...	...	...	...	...
Senile	868	1,596	2,464	31	56	86	131	194	307	227	412	168	378	125	220	32	81	5	9
Involutional	101	135	236	69	95	26	27	5	10	...	3	...	...	...	...	1	...	...	...
Due to other metabolic, etc., diseases	8	6	14	4	4	2	...	...	2	2	...	...	...	...	...	...	...	...	...
Due to new growth	20	13	33	6	2	3	4	7	4	3	1	1	...	...	...	1	...	...	...
With organic changes of nervous system	14	13	27	4	8	6	3	2	1	2	1	...	...	...	...	...	...	...	...
Manic-depressive	42	58	100	22	22	13	27	6	6	1	3	...	...	...	...	...	...	...	...
Dementia praecox	36	59	95	18	34	14	10	4	10	...	4	...	1	...	...	...	...	...	...
Paranoia and paranoid conditions	11	16	27	5	8	5	4	...	3	1	1	...	...	...	...	...	...	...	...
With psychopathic personality	3	3	6	...	...	3	1	...	2	...	...	...	...	...	...	...	...	...	...
With mental deficiency	5	3	8	4	2	1	...	...	...	...	1	...	...	...	...	...	...	...	...
Psychoneuroses	27	44	71	17	21	5	11	4	10	1	2	...	...	...	...	...	...	...	...
Undiagnosed	9	4	13	5	3	2	1	2	...	...	...	...	...	...	...	...	...	...	...
Without psychosis	32	14	46	9	6	14	2	6	3	1	2	2	1	...	...	...	...	...	...
Primary behavior disorders	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Total	2,926	3,323	6,249	608	519	607	529	613	698	531	678	309	507	201	281	49	96	7	13
	1	2																	

this basis, 5,448, or 87.2 per cent, were from an urban environment, and 801, or 12.8 per cent, were from a rural environment. Of the latter, 649 were from the rural non-farm population, and only 152 from the farm population.

TABLE 6.—FIRST ADMISSIONS, AGED 60 YEARS OR OVER, TO ALL STATE AND LICENSED HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, CLASSIFIED ACCORDING TO ENVIRONMENT, YEAR ENDED MARCH 31, 1948

Environment	Number			Per cent		
	Males	Females	Total	Males	Females	Total
Urban . . . . .	2,496	2,952	5,448	85.3	88.8	87.2
Rural . . . . .	430	371	801	14.7	11.2	12.8
Farm . . . . .	97	55	152	3.3	1.7	2.4
Non-farm . . . . .	333	316	649	11.4	9.5	10.4
Total . . . . .	2,926	3,323	6,249	100.0	100.0	100.0

On April 1, 1940, the population of New York State aged 60 or over was divided into 77.8 per cent urban, and 22.2 per cent, rural.<sup>1</sup> It is evident, therefore, that the urban population is over-represented among the first admissions, while the rural population is under-represented. This is especially true of the farm population, which represented 7.7 per cent of the total population aged 60 or over and only 2.4 per cent of the first admissions. First admissions from the rural non-farm population represented only 71.7 per cent of their quota.

*Marital Status.*—As might be expected of a group of advanced age, the majority of such first admissions were either married or widowed. As shown in Table 7, the latter alone included 2,998, or 48.0 per cent, of the total first admissions aged 60 years or over. There were some sex differences, the married representing 37.8 per cent of the male first admissions aged 60 or over, and 18.9 per cent of the females. On the other hand, the widowed included 34.4 per cent of the males, but 59.9 per cent of the females. This is due to the well-known fact of the greater longevity of females. Though the numbers are small, it is also evident that males

<sup>1</sup> See *Sixteenth Census of the United States—Population, Fourth Series. Characteristics by Age*. New York. Washington: Government Printing Office, 1943. p. 5.

include larger percentages of first admissions who were separated or divorced from their spouses.

TABLE 7.—FIRST ADMISSIONS, AGED 60 YEARS OR OVER, TO ALL STATE AND LICENSED HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, CLASSIFIED ACCORDING TO MARITAL STATUS, YEAR ENDED MARCH 31, 1948

Marital status	Number			Per cent		
	Males	Females	Total	Males	Females	Total
Single . . . . .	548	561	1,109	18.7	16.9	17.7
Married . . . . .	1,105	627	1,732	37.8	18.9	27.7
Widowed . . . . .	1,008	1,990	2,998	34.4	59.9	48.0
Separated . . . . .	165	75	240	5.6	2.3	3.8
Divorced . . . . .	50	36	86	1.7	1.1	1.4
Unascertained . . . . .	50	34	84	1.7	1.0	1.3
Total . . . . .	2,926	3,323	6,249	100.0	100.0	100.0

According to the federal census of April 1, 1940, 12.0 per cent of the general population aged 60 or over were single; 48.3 per cent, married; 35.0 per cent, widowed; 4.2 per cent, separated; and 0.5 per cent, divorced.<sup>1</sup> It is evident, therefore, that there are significant differences in the prevalence of mental disease among the aged in relation to marital status. The unmarried exceeded their quota by 47.5 per cent. The married, on the other hand, contributed only 57.3 per cent of their quota. The widowed differ significantly from the married, for they exceeded their quota by 37.1 per cent. This is significant in relation to sex, for the widowers exceeded their quota by 62.3 per cent, whereas the widows exceeded their quota by only 26.3 per cent. Those separated from their spouses reached only 90.4 per cent of their quota, but this was greatly in excess of the corresponding rate among the married. The divorced exceeded their quota by 180 per cent.

*Degree of Education.*—Of the 6,249 first admissions aged 60 or over, 4,972 were classified with respect to degree of education. These data are given in Table 8. Of the total classified, 2,945, or 59.2 per cent, had attended common (elementary) school. A fifth of the ascertained total had received no formal education, though 57 could read and 490 could read and write. Those who had received some degree of

<sup>1</sup> *Ibid.* pp. 23 and 38.

high-school education totaled 747, or 15.0 per cent. Those with some college education totaled 267, or 5.4 per cent.

Compared to all first admissions to the civil state hospitals, this shows a great excess of the illiterate and of those with an elementary education, but a marked deficiency of those with a high-school education. This may be attributed to the fact that the elderly patients belong to a generation that was not subject to the laws that require attendance at school up to a minimum age, which would have brought them to the high-school level.

TABLE 8.—FIRST ADMISSIONS, AGED 60 YEARS OR OVER, TO ALL STATE AND LICENSED HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, CLASSIFIED ACCORDING TO DEGREE OF EDUCATION, YEAR ENDED MARCH 31, 1948

Degree of education	Number			Per cent of ascertained total		
	Males	Females	Total	Males	Females	Total
Illiterate . . . . .	195	271	466	8.5	10.1	9.4
Reads only . . . . .	24	33	57	1.1	1.2	1.1
Reads and writes . . . .	236	254	490	10.3	9.4	9.9
Common school . . . . .	1,389	1,556	2,945	60.7	58.0	59.2
High school . . . . .	307	440	747	13.4	16.4	15.0
College . . . . .	136	131	267	5.9	4.9	5.4
Unascertained . . . . .	639	638	1,277	....	....	....
Total . . . . .	2,926	3,323	6,249	100.0	100.0	100.0

A further comparison may be made with the general population. According to the federal census of April 1, 1940, 10.7 per cent of the population of New York State aged 60 or over had no education; 65.9 per cent had been to elementary school; 14.4 per cent had been to high school; and 5.3 per cent had been to college.<sup>1</sup> If we consider the classifications "illiterate," "reads only," and "reads and writes" as equivalent to the census classification "no education," then the corresponding percentages among our first admissions were 20.4, 59.2, 15.0, and 5.4, respectively. This means that the group with no education exceeded its quota by 90.6 per cent. The group who had attended common school contributed only 89.8 per cent of its quota. Those with high-school or college education contributed almost their exact

<sup>1</sup> *Ibid.* p. 101.

quotas. The outstanding fact is that the illiterate group exceeded by far its quota of first admissions.

*Economic Status.*—Table 9 shows the economic status of the 6,249 first admissions aged 60 or over. Over 80 per cent were either in dependent or in marginal economic circumstances. Only 884, or 14.1 per cent, were found to be comfortable economically. Because of the absence of a comparable classification of the general population, it is impossible to compute rates of first admissions according to economic condition.

TABLE 9.—FIRST ADMISSIONS, AGED 60 YEARS OR OVER, ADMITTED TO ALL STATE AND LICENSED HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, CLASSIFIED ACCORDING TO ECONOMIC STATUS, YEAR ENDED MARCH 31, 1948

<i>Economic status</i>	<i>Number</i>			<i>Per cent</i>		
	Males	Females	Total	Males	Females	Total
Dependent . . . . .	1,059	1,355	2,414	36.2	40.8	38.6
Marginal . . . . .	1,366	1,331	2,697	46.7	40.1	43.2
Comfortable . . . . .	386	498	884	13.2	15.2	14.1
Unascertained . . . . .	115	139	254	3.9	4.2	4.1
Total . . . . .	2,926	3,323	6,249	100.0	100.0	100.0

The group does differ, however, from other groups of mental disorders. Thus, of 1,394 first admissions with involutional psychoses, 37.5 per cent were found to be in comfortable economic circumstances.<sup>1</sup> It is also known that first admissions with manic-depressive psychoses tend to have a higher economic status than the average of all first admissions. On the other hand, first admissions with general paresis<sup>2</sup> and alcoholic psychoses<sup>3</sup> had low percentages of patients in affluent circumstances, and rank about the same as the group of aged first admissions. We may conclude, therefore, that the latter are probably drawn in disproportionate numbers from the poorer economic classes.

<sup>1</sup> See "A Statistical Study of First Admissions with Involutional Psychoses," by Benjamin Malzberg. *Psychiatric Quarterly Supplement*, Vol. 22, Part I. p. 149.

<sup>2</sup> See "A Study of First Admissions with General Paresis," by Benjamin Malzberg. *Psychiatric Quarterly*, Vol. 21, April, 1947. p. 223.

<sup>3</sup> See "A Study of First Admissions with Alcoholic Psychoses," by Benjamin Malzberg. *Quarterly Journal of Studies on Alcohol*, Vol. 8, September, 1947. p. 288.

*Race and Nativity.*—As shown in Table 10, of the 6,249 first admissions aged 60 years or over, 5,979, or 95.7 per cent, were white, and 262, or 4.2 per cent, were Negro. Eight belonged to other races, of whom 7 were Chinese.

TABLE 10.—FIRST ADMISSIONS, AGED 60 OR OVER, TO ALL STATE AND LICENSED HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, CLASSIFIED ACCORDING TO RACE AND NATIVITY, YEAR ENDED MARCH 31, 1948

Race and nativity	Number			Per cent		
	Males	Females	Total	Males	Females	Total
White . . . . .	2,801	3,178	5,979	95.7	95.6	95.7
Native . . . . .	1,432	1,688	3,120	48.9	50.8	49.9
Foreign-born . . . .	1,352	1,475	2,827	46.2	44.4	45.2
Unascertained . . . .	17	15	32	0.6	0.4	0.5
Negro . . . . .	117	145	262	4.0	4.4	4.2
Chinese . . . . .	7	....	7	0.2	....	0.1
Other . . . . .	1	....	1	*	....	*
Total . . . . .	2,926	3,323	6,249	100.0	100.0	100.0

\* Less than 0.05.

Of the general population of New York State aged 60 years or over on April 1, 1940, 97.9 per cent were white, and 2.0 per cent were Negro.<sup>1</sup> Thus the white population in this age group contributed 97.8 per cent of its quota to the number of first admissions, whereas Negroes exceeded their quota by 110 per cent.

The white first admissions included 3,120 of native birth and 2,827 of foreign birth. These represented 52.2 and 47.3 per cent, respectively, of the total white first admissions aged 60 or over. In the general population of similar age, native and foreign whites constituted 56.8 and 43.2 per cent, respectively.<sup>2</sup> Therefore, native whites contributed only 91.7 per cent of their quota, but foreign whites exceeded their quota by 9.5 per cent.

#### SUMMARY

1. Rates of first admissions with mental disease vary directly with age, and are, therefore, highest in old age—i.e., at 60 years or over.

<sup>1</sup> See 16th Census of the United States. *Population. Second Series. Characteristics of the Population.* New York. Washington: Government Printing Office, 1942. p. 13.

<sup>2</sup> *Ibid.*

2. Rates of first admissions at the older ages have increased since 1920, and have increased more rapidly than at ages below 60 years.

3. The expectations of mental disease at age 60 or over have increased since 1920.

4. First admissions, aged 60 years or over, from an urban environment have higher rates of first admissions than the rural population of similar age. The lowest rate of first admissions in this age group is in the farm population.

5. Rates of first admissions were lowest in the married population, aged 60 or over. All other marital groups exceeded their quotas.

6. That part of the population, aged 60 or over, without any formal education exceeded its quota of first admissions by 90 per cent.

7. Compared with all first admissions, those aged 60 or over appear to be drawn disproportionately from the less affluent economic classes.

8. Negroes, aged 60 years or over, have a higher rate of first admissions than whites of similar age.

9. Foreign whites, aged 60 years or over, have a higher rate of first admissions than native whites of similar age.

## VOCATIONAL COUNSELING IN THE REHABILITATION OF DISTURBED AND DELINQUENT BOYS\*

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WHAT effective aid can be given to disturbed and delinquent boys, during their stay on a psychiatric observation ward, that will facilitate their adjustment and prevent further delinquencies? A progress report on a vocational-counseling experiment designed to seek an answer to this question is presented here.

The Bellevue Adolescent Ward receives about twenty-five boys each month for observation, half of whom are referred by the children's court. Their offenses include truancy, stealing, running away from home, fire-setting, sex offenses, assault, and occasionally murder. Not only do they engage in these activities, but they are caught. Upon detection their behavior causes court personnel to suspect mental illness. The other cases are referred by schools, social agencies, parents, and private psychiatrists. The behavior of these boys is similar to that of the cases referred by the court, the only real difference being that they have not had court or police contact.

Most of the children have been in trouble before they come to the hospital; they have frequently been threatened with commitment to Bellevue if they misbehave. Bellevue is "Hellvue" to them, a combination jail and "nut house." This makes it difficult to get from them the coöperation necessary to initiate a constructive psychiatric rehabilitation program.

\* Presented before the staff of the Psychiatric Division, Bellevue Hospital, March 18, 1948.

The lowered sense of self-esteem from which most of the boys suffer is another obstacle to rapport. Among the factors to which they have reacted in a disturbed manner are the following:

1. Disabilities such as reading, speech, or other school deficiencies.
2. Atypical bodily appearance, which exposes the boy to ridicule, such as excessive obesity, over- or under-size, cross-eyes, facial disproportions, acne, and so on.
3. Parental deprivation by loss or separation of one or both parents; lack of parental status because of imprisonment, psychosis, or alcoholism; low economic and social status or feeling of low racial status; and so on.
4. Insufficient emotional security in the unwanted, rejected, or overprotected child.
5. Strong guilt feelings about sexual activities.

These factors have one common effect: they tend to undermine the self-esteem of the children, to make them feel that they are unworthy. Not only does this make the therapeutic relationship difficult to establish, but it is a factor in the genesis of delinquency. The stress of lowered self-esteem may send a child into the fantastic wish-fulfillment of a psychosis, or into delinquency which may lead to a lifelong criminal career. The disturbed child joins the delinquent group because only there can he find the status, acceptance, and satisfaction that he needs. Feeling unworthy and unaccepted, he identifies with the gang group whose activities he recognizes also as being unworthy and socially unaccepted.

This group of boys thus present two major problems. First, hostile and defensive attitudes must be overcome before therapy can be instituted. Second, the boys must be helped to regain their self-esteem in order to preclude further delinquency. The solutions of these problems are related, and an answer was sought in an integrated ward program that would gain the confidence of the boys.

In addition to the excellent school and shop available at Bellevue, an activity program was initiated which it was hoped the boys would enjoy. This includes movies, ping-

pong, shuffleboard, basket ball, softball, wrestling, boxing, leather work, art groups, play-acting, story-telling, remedial reading instruction, and so forth.

Besides these activities and the individual psychiatric interviews, group sessions are held in which the children vent their feelings about ward personnel, and children and psychiatrists discuss their mutual rôles. All of these activities have been very helpful in establishing contact with the boys. One of the most effective means of convincing the boys that Bellevue is a source of help has been the counseling work of the Vocational Advisory Service.

Arrangements with the Social Service Auxiliary of Bellevue Hospital and several foundations permit the Vocational Advisory Service, a private agency, to provide a full-time counselor, a part-time psychologist, and a part-time supervisor for work with these boys.

Vocational counseling is an evaluation and information process that aims to objectify a person's approach to his work. The counselor's effort is to help the person evaluate himself, his skills, interests, aptitudes, ambitions, likes, dislikes, and to compare this evaluation with the demands of various jobs and fields of work. The person then is better able to formulate a plan for further activity, which may be study or work or a combination of the two.

The vocational counselor has three basic tools: the interview, job information, and aptitude testing. As in any good professional inter-personal situation, the interview serves to establish a relationship between the client and the counselor. In addition, the interview provides the counselor with the opportunity to evaluate the client in a number of ways. Job information includes information about the requirements of various jobs, the training necessary for them, where the training can be obtained, union relationships, the availability of certain jobs, and job-procurement procedures. Aptitude testing is the third basic tool.

The Vocational Advisory Service counselors use test scores cautiously. Test scores do not indicate the kind of work a person should do, though they may be interpreted as representing a person's speed and accuracy on a given task. More significant than scores is the actual testing situation, which provides opportunity to observe an individual actually at

work, a condition very different from the one that prevails during his contact with the psychiatrist or the counselor.

While the work situation is artificial, the observations made in it are valuable for an understanding of the individual. For example, speed and quality observations are separated, for they may have occupational significance. At what level of complexity within each area of testing can the person operate? What are his work habits? What is his reaction to the examiner, an authority figure? What tests is he especially interested in? What are his reactions to his environment? The boy's defenses are often down as he works on an interesting task and he may reveal data that add a good deal to our picture of him. The data thus obtained are combined with other material which the counselor has assembled and integrated into a meaningful picture of the individual in question.

These data are interpreted to the boy, and he himself makes decisions about his future activities on the basis of the interpretation. This individual approach to counseling has been developed by the Vocational Advisory Service in its work with normal young people and it has been found that the same approach serves for the boys at Bellevue. In fact, the treatment of them as individuals is usually of the greatest value in obtaining their confidence. These boys have been confined, threatened, and pushed around. Confronted with what is for them the rare opportunity of making their own choice, which is quickly supported by action on that choice, they respond frequently with favorable adjustments.

At staff conferences, the psychiatric, psychological, and counseling findings are compared with the actual performance of the child in the various activities that are available to him. This is done by the reports of the workers in these services who together formulate the diagnostic evaluation of the boy's problem and a plan for his rehabilitation. Vocational counseling continues after the boys leave the hospital, since most of them require continued counseling and supportive follow-up.

Our counseling program has been in operation since March, 1947. Initially, we accepted for counseling children with a variety of disturbances. Boys with schizophrenia, psycho-

pathic personalities, and neurotic behavior disorders were counseled to determine to what extent combined psychiatry and vocational counseling can be used to the advantage of disturbed adolescents. Counseling has been limited only by the age of the boys. Because work permits are frequently involved, counseling is confined to boys of from fourteen to sixteen years of age. Some boys had to be committed to mental hospitals directly from Bellevue and others were sent to reform schools by the courts. We lost contact with some boys after their discharge. A few boys have returned spontaneously to the Vocational Advisory Service after a stay of several months in state hospital or reform school.

Sixty-one boys were referred to the Vocational Advisory Service during the first year of this program. At the end of the first six months, thirteen of the forty boys referred during that period were continuing to adjust well; eight had gotten into serious trouble after their discharge; seven had broken contact with the service; and twelve had been committed to training school or mental hospital directly from Bellevue.

This first group of forty boys shows approximately the same statistics after the second half year. During the second six months, selection was made more carefully and twenty-one patients were referred for counseling. Of this group, thirteen are making a good adjustment; one has got into serious trouble after discharge; three have broken contact; and four have been committed.

It is too early to judge the adjustment of most of the boys. Instead of stressing statistics, it should be more illuminating to describe the progress of four different boys—two schizophrenics, one psychopathic personality, and one neurotic conduct disorder.

The first is a fourteen-year-old schizophrenic boy. He was referred to us because he had been playing truant, staying out nights, and taking excessive doses of aspirin without being able to give reasons for it. He was seclusive, showed a thinking disorder, and seemed aimless and vague. He was seen by several psychiatrists who considered him a hebephrenic schizophrenic with poor prognosis. His I.Q. on the Bellevue-Wechsler scale was 115, with 135 on verbal and 91 on performance parts. The patterning was suggestive of

schizophrenia. The Goodenough figures as well as the Rorschach were interpreted by the psychologist as pointing in the same direction.

The boy received psychotherapy, consisting of sodium-amytal interviews and individual sessions, while he was on the ward. During amytal interviews he revealed that he thought he had contracted syphilis as a result of masturbation. He actually had a herpes zoster on his genitals which frightened him. He had tried to cure himself by taking overdoses of aspirin. He could not think of anything else and could not go to school. After reassurance under sodium amytal and subsequently, he received vocational counseling.

This boy, who had shown a complete lack of affect and interest, was persuaded to return to school, where a placement commensurate with his abilities and aptitudes was arranged. He broke contact with the service and refused to return to the hospital for further psychotherapy after his discharge, but according to the school report, has made an excellent adjustment. The school principal tells us that the boy moped around a great deal at first and did not accept his program, but improved rapidly after a relatively short period of time and at graduation was marked as outstanding in cooperation and courtesy. He is now in high school.

This boy is interesting because he abandoned the vocational-counseling recommendations and formulated a plan entirely his own, with apparently excellent results. When first seen, he expressed a strong interest in natural science and the counselor assured him that a school program could be arranged around this interest. On the basis of this discussion, he agreed to return to school. At school, however, he placed the emphasis of his curriculum on business training.

It would seem that vocational counseling had nothing to do with this boy's readjustment. Experience, however, has shown that abandonment or change of a program worked out with the vocational counselor does not mean that the counseling process has been of no service to the person. On the contrary, people will use the approach of self-evaluation in changing and developing their own programs. To the extent that they begin to think objectively about their interests, vocational counseling has been of service to them.

The other schizophrenic boy was referred to us because he was caught with a gun, together with several other members of a gang. He had the following symptoms:

1. Auditory hallucinations calling him crazy and a fairy, to which he reacted with aggressive outbursts toward innocent bystanders.
2. Visual hallucinations of faces.
3. Disturbances of his body image. He thought that his nose was getting larger and that his hands were getting smaller.
4. Inappropriate affect.
5. Deistic thinking with ideas of grandeur. He thought, for instance, that he had a mission on earth, that he could communicate with God, and that he could think at times, "Rain, stop!" and it would stop raining.

He was treated as a hospital patient for three months. Therapy centered around his art work, individual meetings, and group sessions with three other schizophrenics. The Vocational Advisory Service continued their work with him after his discharge from the hospital.

This gang boy had a perhaps surprising interest in learning to do tailoring and fine needlework. His mother spoke proudly of his sewing feats at home. He was interested in taking a tailoring course and efforts were made to have him admitted to a vocational school that specialized in the needle trades. Unfortunately, he failed their entrance examinations. After this he was admitted to another school close to his neighborhood in which tailoring was taught, but not on as highly specialized a basis as in the first school.

Before he could start at this school, he became involved in a rape attempt which led to his readmission to Bellevue. On reexamination there was no evidence of delusions or hallucinations, no marked thinking disorder, no disturbance of the body image. All that remained of the psychotic episode was the feeling that he still looked funny. He felt that he had been greatly helped by us, that no one before us had understood him, and that he had not understood himself. Once he had gained insight, he had begun to feel all right again. The parents also commented upon his improvement.

Now this boy, with a clearly defined interest and a vocational plan in which he had the backing of his family, still became involved in a serious antisocial activity, a rape attempt with three other gang members. Could a new social environment have been arranged for him, it is possible that he might not have again succumbed to gang activities. Because he was in trouble with the courts again, this boy is statistically counted as one of our failures. We are still working with him vocationally, he has started his tailoring course, and he spends his free time out of his neighborhood. We hope that eventually he will be one of our successes. This story illustrates the tremendous complexity of these boys' problems and the limitations of a strictly vocational-counseling approach to the problem. Increasing success in this work will come as the effort is expanded on a community-wide basis.

The next case was thought to be a psychopathic personality. He also must be counted as a failure at the present time. One of the most colorful characters we have met, this sixteen-year-old boy was referred to us because of running away from home and stealing. He is very obese, having a pituitary type of fat distribution. He had been kept out of school for four years by his mother, who wanted his companionship. He took the precaution of removing his records from the school file before he left, so that he could not be traced.

Both parents are alcoholic delinquents, with a long series of court contacts. The boy's career in crime began at the age of six, when his father taught him to steal, and has continued since.

His I.Q. on the Wechsler-Bellevue was 106, with a patterning suggestive of a psychopathic personality. The Rorschach gave the same impression. He stole everything that he could get hold of on the ward, in school, and in shop. He had no feelings of guilt about his activities, seemed affectively flat, and made no attachments to the ward personnel. His behavior was immature and followed only the pleasure principle. He showed us three little books he had written on how to cheat at cards.

Every one considered him a hopeless psychopath and recommended that he be not included in our group for counseling. Our experiment was just beginning at this time and

we accepted him, none the less, in an effort to test the limits of our service.

Working closely with the court, our recommendations included placement away from his parents, supervision by a social worker, and vocational counseling. He was referred to several endocrine clinics and to a mental-hygiene clinic, and as a final touch, to a magic club, where it was hoped he could sublimate his cheating at cards with more acceptable digital dexterities.

The reference to the clinics proved unsuccessful. One endocrine clinic recommended a breast amputation, and in two other places he was given appointments over several months, with few examinations and no treatments. Treatment at a psychiatric clinic did not include recommendations of surgery, but was equally ineffective in scheduling examinations and treatments.

The main therapeutic work was done through vocational counseling. The boy's interests were diffused and impaired by his feelings of inferiority about his obesity and lack of education. Through the Vocational Advisory Service a scholarship was obtained that enabled him to attend a tutoring school during the summer. In three months, he raised his level from the fifth through the eighth grade. His attendance was remarkably regular, and he made friends with several girl students.

His parents harassed him during this period with demands for money and clothing. Several times he gave them parts of his subsistence checks. This may have had something to do with his next police experience. He was in jail for five days for carrying bags without a license at a railroad station. Some months later he was arrested again for the same offense and received a six-month suspended sentence.

After completing school, he was placed in a job which he promptly lost for failing to deliver a package, taking it home with him instead.

Efforts were then made to have him admitted to a high school where he could take a commercial course in which he had begun to show interest. This would seem a rather easy thing to accomplish, but the resistance of school principals to accepting a boy with a court record is amazing, if not admirable. Finally, he was placed in a vocational high school

only because it was hoped that he could develop a school record that would permit his transfer to a commercial high school. The vocational-school admissions officer professed great sympathy and understanding for this kind of boy: "I had five hundred hours of abnormal psychology." Soon this sympathy was dissipated by a barrage of truancy and petty thefts.

This situation failed to develop into a school crisis because the boy was hospitalized for suspected appendicitis. Several days later we received a telephone message allegedly from the hospital, stating that the boy had died of a ruptured appendix and had given his psychiatrist's name as his nearest relative. Soon after this, we were shocked again by the appearance in the flesh of this boy who, months later, admitted that he had exaggerated the news of his own death.

Through the New York State Employment Service, he then obtained a job which he promptly lost for stealing a fountain pen. With this dismissal, the employment service felt that they could no longer endanger their reputation by referring him to employers. The boy soon secured a job from a private employment agency, as an office boy. After two weeks, he was discharged for stealing and it was decided to bring him back to Bellevue for further observation and reevaluation.

On reexamination, his I.Q. had improved from 106 to 121. His obese condition was unchanged, but psychiatrically, he showed capacity for relationship and signs of real affect. He has demonstrated signs of identification both with the psychiatrist and with the counselor, which may be the beginning of the development of a super-ego. He has told the other boys that he makes trips with the psychiatrist and he has asked the counselor what courses of study he must take in order to qualify for the counselor's type of work. More important from a therapeutic point of view, he now feels that his stealing is a sign of sickness and has asked that he be helped to cure this illness. Funds were secured for referring him to a private psychiatrist who, after several months of regular contacts with the boy, feels that he is capable of benefiting from therapy.

Statistically, this boy is carried as one of our failures, even though we feel that our combined service has been of value to him and can point to definite progress. It is tempting, of

course, to select his improved intellectual functioning as such a sign, though we still must face the possibility that he may use this improved functioning in more effective stealing. Nevertheless, through long, consistent, steadfast contact which he has never had before, a psychopath, felt by many professionals to be beyond the reach of therapy, establishes relationships, begins to show appropriate affect, and comes to recognize his delinquencies as an expression of illness.

There are several features in this case that are pertinent to the problem of a combined rehabilitation effort. Four people of as many professions have collaborated closely in this boy's program: psychiatrist, social worker, probation officer, and counselor. Some people feel that contact with several persons may interfere with the psychotherapeutic approach. Our experience has shown, however, that at no time did the work of one person with the boy interfere with the work of the others, so that the total effect was a therapeutic relationship between the boy and a professional family. Collaboration of this kind, to be effective, requires, of course, planning and free lines of communication.

Another feature in the case is the difficulty in getting a boy with this kind of problem accepted in a school of his choice. Employers also are reluctant to hire these boys, and many tell us that they would prefer to make a contribution rather than to become involved with the boy himself. These attitudes are, of course, directly detrimental to the health and progress of our boys and also serve to limit the effectiveness of our experiment, since we are sometimes unable to execute our recommendations. Such lack of coöperation and the inadequate facilities for handling these boys frequently contribute to a feeling of pessimism on the part of those who work with them. In this boy's case, the probation officer had felt for a long time that the boy's future was hopeless and that we were all wasting our time. Continuing his coöperation, however, he began to change as he detected signs of change in the boy, and he has come to feel that there is a possibility of rehabilitation. It was both refreshing and amusing when the children's court judge, placing the boy on probation for the second time, counseled the counselor, "Don't get discouraged. He's probably going to steal again, but we've got to keep working with him because he shows promise."

The cases we have presented are among those that we consider the least successful, but they demonstrate the complexity and severity of the problems that young adolescents frequently must tackle without help of any kind. In each of these cases, we feel that we could have been more successful had we been able to control each problem that we recognized. With less severely disturbed boys, we have observed that assistance with one of their manifold problems frequently releases them to cope better with the others. Our next case demonstrates this, as well as the effectiveness of counseling in raising self-esteem and thus precluding further delinquency.

This is a sixteen-year-old boy whose mother brought him to the hospital because he played truant, was destructive at home, made funny noises, blinked his eyes, and complained of visual and auditory hallucinations. Years before, he had been seen on a children's ward where the diagnosis had been severe psychoneurosis with major ties. We made the same diagnosis and treated him with hypnotherapy.

The boy is very undersized and his short stature was a constant cause of concern to him. His mother, who was separated from her alcoholic husband, exerted constant and heavy pressure on the boy to make money. He was attending a vocational high school, where he was doing excellent work in electricity. Our interpretation of his aptitude-test performances was helpful in giving him much self-esteem which he badly needed. He showed exceptional ability on tests measuring elements of mechanical aptitude, and his I.Q. was high average. He wanted to remain in school and, to facilitate this, we obtained a scholarship which provided him with lunch money and car fare. The pressure from his mother continued, and in an effort to cope with this, we helped him secure a part-time job. This, however, was not enough to satisfy the mother. Her pressure continued and the boy finally attempted to enlist in the army. His application was turned down and he left school to look for a job.

We asked the employment service to consider his highly developed mechanical aptitudes and interests, and they placed him as an apprentice typesetter. The boy is very happy in this work and several weeks after starting on the job, he asked for help in making arrangements to continue his education at night.

This boy demonstrates the easy shifting of interest of young people who have had little work experience. He acquired some familiarity with electricity in school and, therefore, wanted to become an electrician. Placed in an actual job, he became acquainted with typesetting and now wants to become a typesetter. In both cases, vocational-counseling evaluation served to underwrite his interests. We have received weekly reports on the boy's adjustment and can safely say that within a six-month period, his behavior has changed radically for the better.

To summarize, after one year of combined psychiatric and counseling efforts, we are able to state that vocational counseling has helped us to gain the confidence of many boys and has made it possible to initiate psychotherapy. Our best results have been with neurotic boys. Several boys diagnosed as schizophrenics have been treated with less effectiveness and more variable results. It is likely, however, that as the service to these boys is continued, a more accurate evaluation of our efforts will result. Among adolescents, there are certain cases of mental illness that resemble schizophrenia and that seem to be amenable to psychotherapy, but whose improvement has to be safeguarded by a great deal of continued work. With adolescent boys in our age group, vocational counseling has proved to be an effective supportive therapy. The psychopathic personality is still one of the most difficult problems to treat. Such individuals require an exceptionally large amount of work and within the limits of our present set-up, we cannot afford to take a large number of them. We are, however, carrying several psychopaths and in a year or two hope to be able to report on their progress.

At no time have we found that vocational counseling interferes with psychotherapy. On the contrary, it has always been helpful; sometimes it has been the opening wedge to therapy, and occasionally it has been the only way in which we could maintain a relationship with the boy.

Some school and social-agency personnel and counselors still have resistance to working with children who have psychiatric problems. Community education toward an understanding of the graduated differences between normality and abnormality is a necessary further step in establishing a

realistic rehabilitation program. Beyond such understanding, community participation is imperative.

It is sometimes argued that a rehabilitation program on a community scale is prohibitively expensive. Consider that the vocational-counseling program we have described costs on an average of \$200 per capita for our group of boys. Compare this figure of \$200 per person with the cost to the community of months of incarceration in a state hospital or a correctional institution. When one adds to this cost the incalculable price of suffering to the boys and their families, it becomes clear that adequate rehabilitation efforts are a social economy, not an expense.

## FACTORS THAT DETERMINE THE TIME WHEN CHILDREN ARE REFERRED TO PSYCHIATRISTS

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**C**URIOSITY has often been expressed as to why children are brought to a psychiatrist at a specific time, not necessarily coincident with the onset of the complaint. Sometimes the problem, as formulated by the patient or his parents, has been in existence for a considerable period—often months or years. At times, the presenting symptom as such has long been in evidence, yet has not had sufficient nuisance value to be offered as an admission ticket to a psychiatric clinic. In other cases, anxieties and irritations have been playing havoc with parent-child relationships, yet the thought of seeking psychiatric help either has not occurred, or has been pushed aside, or even resented if suggested.

Obviously, therefore, the request for an appointment is not determined solely by the appearance of a problematic behavior manifestation, no matter how conspicuous and obtrusive it be. There must be some other significant factors that act as "precipitating causes" of the decision to call for psychiatric help. At some particular juncture, the poignancy of the difficulty becomes so great that the parents or their advisers request psychiatric evaluation of the situation and help in dealing with it. The situation often then is formulated as an emergency.

In an attempt to determine the precipitating factors responsible for the precise timing of an initial psychiatric examination, a study was made of the cases examined during a three-months sample period. In this time 92 children were seen in private consultation or in the out-patient department of the Children's Psychiatric Service of the Johns Hopkins Hospital. All of the staff members were alerted to ask parents and patients in detail about their reasons for coming to the psychiatrist at the specific time they did come.

Of the 92 cases, 71 were referred by other physicians (25 from private pediatricians, 21 from pediatric wards or outpatient services, 15 by general practitioners, 10 from other specialists in chest, cardiac, endocrine, otolaryngologic, epileptic, spastic, psychiatric fields); 15 were referred by social agencies (eight from schools, seven from other agencies); and six were brought solely on their parents' initiative.

The complaint problem can be equated with the initial reason for seeking psychiatric help. These problems can be divided into six categories: somatic complaints without sufficient or any organic cause (33 cases); behavior problems (26 cases); symptom-management problems—*e.g.* feeding difficulties, hair pulling, breath holding, overdependence, speech and reading disabilities, and so on (13 cases); evaluation and advice regarding questionable mental retardation (12 cases); management problems in the care of special physical disabilities—*e.g.* spastic, epileptic, deaf, and so on (7 cases); confirmation of diagnosis of autism (1 case).

Some of the precipitating situations that bring children to the psychiatrist are illustrated in the cases that follow.

Tommy K., a physically healthy, intelligent boy, of four and a half years, was referred to the clinic by his pediatrician. The child had "always had stubborn streaks," and about one year prior to psychiatric consultation, he had had gastric upsets, with severe vomiting for about a month. The patient's temper tantrums were presented as the chief complaint, yet they had existed in major proportions for some months before his mother became sufficiently concerned to seek professional help.

A few weeks before Tommy's father was due to return from three and one-half years overseas, Mrs. K. somewhat frantically requested psychiatric help to "make the child good" quickly. In the course of study, it appeared that her feeling of acute crisis stemmed largely from fear lest Tommy's behavior reflect badly upon her ability as a mother and wife. Mrs. K. felt insecure with her husband and was afraid that he would blame her for the child's "bad" behavior, thereby becoming alienated from her. Mr. and Mrs. K. had not been married long when he had had to go overseas. At first his letters had been long, full of yearning for her, and

came every day. As time went by, they had become less eloquent, arrived less often, and were shorter—to the point of seeming brusque and indifferent. Mrs. K. had heard and read about husbands, separated from their wives by the war, who returned as cold, distant strangers. Was this happening to her? When only a few weeks remained before Mr. K. would be home and Tommy's misbehavior continued unabated, Mrs. K. became panicky.

Mrs. K. was a social worker who was much happier doing social work than doing housework. Tommy was left in the care of a nurse who was an emotionally inadequate person. The nurse combined overprotection with pushing, unfulfilled threats, and manifestations of jealousy of the mother. The child's three hours per day in nursery school offered some, but not enough, surcease from the nurse's erratic vigilance. At school, the child's behavior caused no concern. However, during the four weeks prior to being seen in the clinic, his temper outbursts at home assumed alarming proportions. He wanted to get into the cellar and, when he was not admitted, broke the window. On another occasion he started ripping the seats of the automobile and, when he was stopped, retaliated by smashing the car window. He was destructive in other ways. He had "shredded the newspapers" and had "littered more than one hundred books on the floor." Once when he refused to go to bed and threatened to leave the house, his mother told him to go ahead, while the nurse tried to keep him from doing so. Thereupon, Master Tommy, in his pajamas, wandered off and got lost. When he returned, the nurse was so upset that she went to her room to vomit.

This was the last straw. Mrs. K's feeling of failure and frustration about the child frightened her. Its portent—in terms of her marriage—was even more alarming. Thus, only when the marriage seemed imminently threatened and she felt completely baffled and beaten in the situation, did she finally seek help.

The specific situations that motivate parents to bring a child to the physician when they do, appear to be unique in terms of each family. Many children seen by psychiatrists have been a sufficient worry to their parents to have been

taken to the pediatrician or the general practitioner—often on many occasions—before the emotional character of the disturbance is recognized. These parents are sincere in their desire for help. In fact, it is not always help for the child that is the primary expectation of parents. This is sometimes implied and sometimes openly expressed.

The mother of eleven-year-old Ann introduced herself with these words: "I have thought so much about Ann, and considered for many years what I should have done and what I shouldn't have done that I've got myself very much involved in this. I have waited eleven years for this." Ann's eleventh birthday, criticism by the mother's friends and relatives, the child's struggle for emancipation—leading finally to unpleasant clashes—all acutely activated the mother's puzzle about her maternal rôle. Thus, when she brought Ann, it was she herself who she hoped would be the principal beneficiary.

Physicians are sometimes as frustrated as the patients and parents. They are often perplexed by their difficulty in evaluating the situation. The ordinary remedies fail. Without a proper diagnosis, the treatment is doomed to failure. Even if emotional factors are recognized, the busy doctor's annoyance with the "fussing" of the parents is all too prevalent.

Mary A. was referred to a psychiatrist at four-and-a-half years of age. All the local doctors had been consulted repeatedly, and extensive diagnostic studies had been undertaken, to no avail.

From the time she was six weeks of age, Mary had been taken from one doctor to another as "an allergic child." Various diets had been tried. Numerous and varied régimes had been offered the mother without alleviation of the difficulties. Mrs. A.'s overconcern increased as the doctors seemed annoyed and frustrated by her complaints about the child. None of the local doctors could put a finger on an etiologic "it."

Exhausted, distraught, and frightened, Mrs. A. could find no cause or cure for the multiple allergies with resultant dermatoses that the child seemed to manifest, in spite of her fantastic, obsessive efforts to succeed where the doctors had failed by eliminating all possible environmental culprits. She kept astonishingly elaborate and complicated charts of every-

thing the child did, ate, or wore. Finally, in a state of near collapse from her frantic efforts, she brought the child to the Johns Hopkins Hospital for a "complete study."

Mary was hospitalized in the Harriet Lane Home for diagnosis while the mother was going through the diagnostic clinic to discover the etiology of her own allergies. For the first time the psychogenic factors were recognized, and a psychiatrist was consulted. The child had no physical defects, nor was there the least evidence of any skin lesion. This was in marked contrast to the mother's story that the child was "allergic to everything" and "broke out in a rash all the time." In contradistinction to the child, who was literally a picture of health, Mrs. A. looked disheveled, thin, and tired. She chain-smoked and cried easily.

The only child of Mrs. A.'s second marriage, Mary had been much desired, but she and her husband had questioned the wisdom of having a baby when she was thirty-six and her husband forty-eight. Nonetheless they had had the child. At the time of Mary's birth, the parents started a routine calculated to produce a "perfectly normal child." "Since she was the only one and she came so late," her mother stated, "we were always trying to protect her and afraid something might happen to her . . . I've watched her every minute since she was born . . . I've even slept with her since she was nineteen months old . . . She was all right until she was six weeks old and had bad colic with her orange juice. Then she broke out in hives . . . When at six months I changed her formula to pasteurized cow's milk, she broke out in the most awful welts. I was so upset and cried. I know there must be some physical basis for this. It's not possible for a mental attitude to have this much effect on people . . .

"We've tried to give her milk and eggs and wheat, but they all make her break out. Of course, those were the things I have always been allergic to, so she never got any when I was pregnant. I have tried to make it up to her by giving her vitamins and special foods. It's been hard to give her a good diet when almost anything gives her hives or some worse kind of allergic itching eruption . . . Nothing we give her helps. She's a perfectly normal child except for these physical allergies.

"Two months ago I noticed she had a dermatitis that swept

up from her urethra over her entire body to her navel. Maybe the dye in her clothes causes it . . . We've taken her to every doctor in ——— and none of them can help her. They all send me somewhere else and then I get no help. I just don't know what to do. The thing I want most in the world is to have a perfectly normal child without these allergies. I'm so tired and worn out. The doctors at home thought that in the long run it would be best for both of us to come up here and see if we couldn't get straightened out."

Thus, at long last, Mrs. A was referred to a psychiatrist—incrédulous, but relieved and grateful for some prospect of help.

At least we had an opportunity to see Mary A. at four-and-a-half years of age and she and her parents could be helped then. Very often the precipitating cause does not come until the child is in more serious straits physically and is well on the road to a pattern of emotional invalidism. It is a common thing to see children who have been sifted through many doctors, each of whom suggested some type of treatment—ranging from repeated surgery to extreme and inadequate diets—without any recognition of the emotional etiologic factors. Often a short period of uninterrupted listening to the patient or parent would unearth the roots of the trouble. Children sent from doctor to doctor, and treated by each with a different remedy, are less common as pediatricians and other physicians become more aware of emotional problems. However, the therapeutic despair of general practitioners and pediatricians who finally decide that "this must be a case for a psychiatrist" represented the most frequent reason for the reference of patients to the Children's Psychiatric Service of the Johns Hopkins Hospital during the three months of the study.

Bright little Rose W., at the age of seven and a half, was wise in the lingo of the medical world. She could and did rattle off the various diagnoses and treatments offered for her headaches and repeated vomiting spells. Since her parents' divorce about three years before, she had been having bad headaches. With her mother's remarriage, the vomiting began. In her home town she was hospitalized repeatedly. Yet no one even made any chronological connection between the symptoms and the child's environmental situation. Electro-

encephalograms, gastrointestinal series, and blood-chemistry determinations had been done. Penicillin, various of the sulfa drugs, barbiturates in sizable quantities, and other empirical treatments had been given in the vain hope that they could stop "the awful vomiting that is breaking us all up."

The patient spoke of her symptoms as if they were prized possessions, as indeed they were. She made it clear that her mother had similar difficulties. Rose attracted attention with her "spells." Not only did she worry her mother and stepfather, but she was an object of curiosity among the local physicians. She announced that the doctors had told her she had "pernicious vomiting" and that she had heard them talking about a "brain tumor."

Each of the ten or eleven times hospitalization had been necessary because of dehydration and acidosis resulting from vomiting, the child had received intravenous fluids, sedation, penicillin, or sulfa drugs. Her mother or stepfather stayed with her day and night. This was no ordinary thing. She lost weight and each episode was worse than the last. The child was feverish, hollow-eyed, restless, a picture of dejection, fear, and general distress with each spell. No matter what the doctors did, she responded poorly or not at all.

The local doctors called on the physicians from the nearby veterans' hospital. Still Rose vomited. Finally, desperate and afraid that the child would die, the stepfather flew with her to Johns Hopkins Hospital.

The pediatric staff could find no organic disease. True, she was dehydrated, but the vomiting stopped promptly. She began to eat and drink well. On the first hospital day she was seen by a psychiatrist. Rose affected a blasé attitude that would have seemed ludicrous had it not been so tragic in a seven-year-old girl. She was thin and looked tired and worn. Shortly afterwards the pseudo-sophistication was lost as she became interested in playing house. On a children's ward, separated from her parents, she soon was outgoing and happy. She began to express her feelings about being "pushed out" by the stepfather, and she could state that her mother "gets sick like I do. She does it when she doesn't want to go to work." A few days before Rose left the hospital, she announced that she was "tired of being sick."

Although the parents may bring a child for examination

because of bodily symptoms, alert pediatricians recognize that the youngster may be in serious emotional difficulty. It is a frequent picture to find seemingly conscientious, well-meaning parents who succeed—albeit unwittingly—in putting such pressure on the child that their own obsessive ambitions for achievement beyond the capacities of the child overwhelm him. He wants and needs to please the parents. Yet his own abilities may be utterly incompatible with the expectations of his parents and ultimately with his own.

Martha R. was seen in consultation because the pediatrician recognized that the child was emotionally very sick. There was no organic explanation for the four bouts of obstinate constipation and leg cramps with which she was originally brought to the hospital. It was remarkable that, in spite of an I. Q. under 90, this thirteen-year-old girl had always been an excellent student. Until the year before, she had had an "A" average and currently was maintaining a "B" average. In the child's eyes and in the eyes of her parents, this represented failure. Yet, to achieve her goals, she had to work extraordinarily hard—spending long, tedious hours with home work while other children were playing. Nor did this stop with school work. Her meticulousness extended to her piano practice, her dancing lessons, and her personal appearance.

One's first impression was of a charming, gracious child who appeared tense and anxious to please. She had "always been a very good child" who had high, perfectionistic standards for herself. As the work at school became harder, the child felt that she was fighting a losing battle to maintain her record.

Martha was an only child whose parents wanted her to "be a little lady and go to college." They wanted her to be accomplished in a number of social graces in which they felt themselves deficient. Through their only child, they hoped to realize many of their personal ambitions. Somewhere their calculations went amiss. Mrs. R. found that she had a "too good" child on her hands. "A little old lady at thirteen!" Therefore, the parents tried to get the child to "let up a little and play more." Such behavior, however, meant inferior performance in the areas in which she had found almost the only approval she knew. This the patient could not tolerate.

In spite of almost superhuman efforts to maintain her place in the class, she could not do it, and she reacted violently with "spells" of obstipation lasting several days. These refused to respond to heroic doses of cathartics and enemas. With each "spell" the child would have to be hospitalized to have the fecal impaction broken up.

The emotional price the child was paying for her exemplary behavior and performance was manifested by many symptoms: difficulty with constipation since eighteen months of age, with "mineral oil every night of her life since then"; breath-holding spells from three to five years; other marked evidences of inner tensions, such as being "always on the go," stuttering, grinding her teeth at night, biting her nails, twisting in bed at night, sucking her thumb when tired, and having numerous and varied fears. In spite of all of these signs of emotional trouble, it was not until the child repeatedly reacted so violently with obstipation to the too-heavy pressures put on her by her parents and by herself that the mother's concern became severe enough to cause them to seek diagnosis and psychiatric help rather than symptomatic care.

It frequently happens that after all the available community social resources have been exhausted, the psychiatrist is consulted in desperation. Too often there is the blind hope that the psychiatrist can work a miracle of cure or at least suggest a fool-proof solution for the social dilemma.

"Problem" children are brought into the psychiatrist's focus at times of situational crises. Often the beginning of school; failure, or the threat of it, at the end of a semester; unacceptable sexual activity in the psychotic or feeble-minded; criminally delinquent acts that involve the police and courts; parental abandonment; or the presence of physical handicaps are the situations in which our social agencies no longer can offer sufficient support. The schools and courts urgently seek psychiatric help in the management of children who do not fit into the prescribed pattern. Occasionally the immediate problem is acute, often it is chronic and unsolved.

The verdict that a child is a mental defective or is psychotic poses not only a management problem, but an emotional hurdle which parents sometimes find it extremely difficult to surmount. The majority of retarded children may be prob-

lems in the family, but are rarely social problems until the environmental stresses increase to the point where the children's resources are wholly inadequate to meet them. Evaluation of the severity of the disorder, the prognosis, and proper plans for care and treatment are essential and frequently requested. The psychiatrist can be of real help both to the family and to the social agency if understanding and support can be given to assist the parents to accept the reality and to plan intelligently for the child's care.

Closely allied with the sociological problems *per se* are the school difficulties that become high-lighted at promotion time. To all concerned, it long may have been obvious that the child's behavior was "out of hand." However, the school's ultimatum that "unless something is done, we cannot and will not tolerate the child in school any longer" is the usual precipitating cause for seeking psychiatric help.

The parents may have been annoyed with the child's behavior at home, angry and disgraced by the poor school performance. Yet often it seems to take a definite stand on the part of the school regarding the unacceptability of the child's behavior to precipitate the decision to consult a psychiatrist. True enough, there are many families who know nothing about the availability of psychiatric help. There are many others who consider coming to a psychiatrist a tacit admission of being "crazy." This they wish to avoid at all costs. However, when an ultimatum is delivered by the school, the parents come—often skeptical and resentful, but grateful when they see a possibility of help.

Maria S. came from a home that was by no means ideal. There were five children, products of her mother's two marriages; a carping stepmother, with whom the child was required to spend part of her time; a fussing grandmother; a stepfather who was often drunk and occasionally brutal; a rather inadequate and always harassed mother; and little economic security. Although the members of the family were often at one another's throats, it was Maria who seemed to be causing the most turmoil at this time.

Maria was eleven and a half. She had failed in school three times. Her mother had been told "her I. Q. is not very high" (it was 88). The child seemed to be becoming increasingly fidgety and "nervous." Mrs. S. stated, "She seems

scared all the time and won't eat right. She jumps when anybody hollers at her. She runs after me all the time, so I can't get no work done. She sulks and cries and drives us all crazy." Maria was in danger of failing again because she couldn't "get her arithmetic or reading." The school had summoned Mrs. S. on numerous occasions because Maria was so jittery in school, didn't pay attention, and "wouldn't mind." Mrs. S. felt herself trapped by the child's continued and progressively more troublesome behavior. Mr. S. was angry because the child was "in the way and didn't appreciate a good home." The grandmother constantly scolded Mrs. S. for not being able "to get the child to stop whining." Mrs. S. felt more and more irritated with the child and, though she increased her nagging, Maria did no better. With the end of the school semester approaching, it was again almost a certainty that Maria would fail if something was not done. The principal suggested and almost demanded that a psychiatrist be consulted. So the S.'s came to our clinic.

The children thus far discussed have been in serious emotional difficulty. At least we could evaluate them and proffer help relatively early in the child's life. A goodly number of children and their parents survive the vicissitudes of childhood, school adjustment, and even such real disabilities as physical deformity without great strain or pain to any one involved. However, with the new problems that appear during adolescence, the picture often changes.

Now, for the first time, some parents find that they cannot tolerate the signs of budding independence and refusal to conform to their prescribed standards of behavior. Boys and girls occasionally writhe with "growing pains" in the throes of their rebellion before finding a comfortable adult stability. To themselves and to those who love them, it sometimes seems that the storm will capsize the boat. Any one who cares to look can see that the adolescents who are having a rough time have not been without problems before. So often we see the picture of a youngster who has been a conforming, "good" child. As the child begins to exert his independence and pull at the apron strings, the parents are overwhelmed and attempt to enforce, by any and all means, the compliance with parental rule which they have previously known.

John J. was brought by his parents at sixteen years of age.

He was an only child. His mother explained that they could not afford more than one child. They were by no means indigent people. In fact, they were affluent, had a large home, servants, and many luxuries, took long and expensive trips in the summer. But they felt that John should be made the sole recipient of their wealth and of that which they thought was affection.

The mother's two brothers, reared by an extremely domineering mother, had rebelled in their adolescence, and had been driven away because of the disgrace they had brought on the family. They had come into conflict with the law. John's mother had reacted to the same emotional climate with the development of rigid perfectionism. The man whom she had married was a successful, self-made merchant, rather soft-spoken, but greatly impressed by the general claim that the path of virtue and righteousness is so straight and narrow that one must incessantly take precautions against the danger that one's foot or elbow might reach out beyond it and be clipped off. Both parents were unable to shoo away the vision of John's two uncles and lived in dread lest some day the family's "bad blood" assert itself in John. They set out to counteract this peril by trying to attain perfection in the body and spirit of their child.

Perfect feeding habits were achieved with the help of coercion and tonics. John's ankles were bandaged to assure perfect gait. "The necessity of being honest" was pointed out to him in long sermons. His home work was inspected and judged before he was allowed to retire. His playmates, the moving pictures he attended, his reading materials were pre-selected for him. John accepted all this with seeming equanimity. He was a "good" boy, convinced not only that his parents knew best, but also that there must be something within him that made all these measures imperative. He felt guilty when his school report said "good" instead of "excellent."

A small boy until fourteen years of age, he then began to shoot up rapidly and was a six-footer when he presented himself at sixteen. The parents complained at that time that he "didn't know his own mind, neglected his school work, didn't know what to do with himself, had no pep whatever." This

behavior they countered with more sermons, predictions of a worthless existence, refusal to let him go to ball games or to drive the family car until he produced better marks. When this brought no results and the parents felt their security and position as able mentors challenged to the breaking point, psychiatry was resorted to.

A tall, lanky boy came into the office and sat down listlessly. He had come, he said, because nothing made any difference to him any more. His parents had never trusted him and they were obviously right. Ever since he could remember, they had always criticized him about everything. He had never known how to satisfy them. They treated him like a little baby and perhaps he was one. Oh, yes, he had many friends and was popular with them, but his parents found fault with most of the boys and girls with whom he wished to associate. The main trouble started when the question of choosing his high-school course had come up. His parents wanted him to become a doctor and, therefore, take the academic course. For the first time, John had the courage to act on his own inclination and signed up for the general course. He paid dearly for this. There were incessant references to his ingratitude, his stubbornness, his lack of consideration and lack of coöperation. He was made to feel that he had let his parents down. When, under these circumstances, he had no zest for work, even in the general course, and his marks began to slip, he was made to feel that this was the result of the poor choice he had made.

John was crushed and defeated when he came for the interview. He had given up trying, he said. What was the use? He kept up this attitude for some time, but relaxed more and more when he found himself accepted and rid himself of the suspicion that the psychiatrist would be another preacher of sermons. When he felt that he could speak freely, he cheered up, talked about his delight when, on Saturdays, he was allowed to work in his father's store, recalled an incident when he had succeeded in making a substantial sale when his father had failed, and spoke enthusiastically about going to business college.

It took some time to help the parents, especially the mother, to accept John as he was rather than as an ectoplasmic exten-

sion of their own desires. While this was being accomplished, John was able to build up his identity without being made to feel guilty about it. His apathy, which in reality had been a pathetically painful defeatism, gave way to increasing self-confidence and self-assurance. His school work improved. He once referred to his first visit to the psychiatrist as his Fourth of July.

To conclude, it appeared that, in the 92 cases studied, the precipitating cause for seeking psychiatric help was a crisis arising in the child's environment. This might be due to the parent, to the physician, to a social agency—most often the school. The specific timing of the initial psychiatric consultation seemed to be determined, in significant measure, by certain life situations:

1. The overprotected child finds it difficult to make the initial adjustment to kindergarten or first grade (15 cases).
2. The approach of the time when promotion would normally occur precipitates reference of the child who is not doing well in school (16 cases).
3. The new demands of pre-adolescence and adolescence bring an emancipation problem to the previously "good" child (9 cases).
4. Therapeutic despair makes the general practitioner or pediatrician decide that "this is a case for the psychiatrist" (37 cases, the largest group by far).
5. Somewhat similarly, social agencies, after struggling unsuccessfully with difficult sociological situations, turn in despair and hope to the psychiatrists for a situational solution or an evaluation and resolution of the personality problems involved (15 cases).

## A PLEA FOR EDUCATIONAL THERAPY IN MENTAL HOSPITALS

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**E**ARLY in 1944 an experiment in educational therapy for patients was inaugurated at Worcester State Hospital. One year later, this program passed from the experimental stage to a more permanent basis. And now, after four years, the time seems ripe to evaluate the program, review its progress, and make certain recommendations and suggestions that might well be followed by other state mental hospitals and institutions.

This educational program is carried on by the use of correspondence courses from the Massachusetts Department of Education, Division of University Extension. These courses are available, free of the customary charge, to the residents of any Massachusetts state institution. Any required textbooks are now furnished by the state department of mental health, although in the early days of the program public-library books were used. With the assignments, the paper, and the correctional service furnished by the state department of education, and the supervision of courses and textbooks by the department of mental health, there is no expense whatsoever to be met by the patient. For an individual outside of an institution, the same correspondence course would cost approximately ten dollars.

Each course consists of from eight to sixteen assignments. As each assignment is completed, it is mailed in to the state department of education, division of university extension, in Boston, where it is corrected and graded by a competent instructor. This instructor is impartial, he does not know the patient personally, and he corrects and grades these assignments on the same basis as all the other assignments from individuals who are paying for their courses, from veterans, those in tuberculosis sanatoriums, or those in penal institutions. At the successful conclusion of a course, a cer-

tificate is granted by the state department of education, and, when desired, a supervised examination may be taken to obtain high-school or college credit.

How does this program function? What are the mechanics involved? First of all, the program is carried on and supervised by a trained teacher—one who has had several years of experience both in public and in institutional teaching. She acts as the intermediary between all the cooperating agencies within the hospital itself—the doctors, the nursing department, the occupational-therapy department, the psychology department, the social-service department—and the patient himself, and also as the intermediary between the patient and the department of education. References are made to the instructor, by any members of the staff, of new patients who might benefit by educational therapy. These patients are interviewed, the general program is explained, and a choice is made from the 177 courses offered by the division of university extension. Whenever possible, a vocational course is chosen, with the hope that it may prove of practical value when the patient leaves the hospital and seeks employment.

When the course has been selected, an application blank is filled out, giving the individual's previous educational and vocational background. This is approved by the superintendent of the hospital and is sent in to the division of university extension.

As soon as the course arrives, the instructor again visits the patient, explains the best procedures and methods of study, and makes arrangements for collecting the assignments as they are completed. When necessary, the instructor has a class hour with the patient, giving whatever assistance seems necessary. In most cases, however, the patients prefer to do all the work themselves and thereby derive full credit for it. With each patient there is a definite understanding as to when and how often assignments are to be collected. These are immediately sent to Boston for correction and are returned to the individual patients as soon as they arrive back at the hospital. Any one assignment usually requires from six to eight hours of preparation, and an attempt is made to have them handed in with regularity—usually one a week.

During a two-year period, complete records have been kept

on each patient who has taken an extension course. These records give the person's age, diagnosis, name of the course, the date when the course was started, when each assignment was sent in and the grade received, and when the course was completed. The following data have been compiled from these individual records:

Eighty-three patients have taken courses, 39 men and 44 women. The average age of these patients was 33.7 years—31.44 for men and 35.93 for women. The youngest patient was fifteen, the oldest seventy.

The diagnoses of the 83 patients seem representative of state-hospital populations. They are as follows:

Dementia præcox .....	42
Psychopathic personality .....	7
Paranoia .....	5
Involutional melancholia .....	3
Manic-depressive .....	9
Psychoneurosis .....	4
Undiagnosed .....	5
Miscellaneous .....	8

One interesting fact is the comparatively high number of those with a diagnosis of paranoia or dementia præcox, paranoid type—namely, 16—who have successfully carried on educational work.

These 83 patients have taken 143 courses, including 62 different courses. Courses of a vocational nature, such as salesmanship, shorthand, bookkeeping, and practical applied mathematics, have predominated, accounting for 28 courses. Next in popularity are mathematics, with 15; art, with 14; home economics, with 12; English, with 12; Spanish, with 6; French, with 5; journalism, with 5; and science, with 5. The remaining 41 courses are scattered among miscellaneous subjects.

Of these 143 courses, 82 were completed, and certificates were issued. The 82 completed courses represent the work of 40 patients, 14 men and 26 women. Although they are allowed to take only one course at a time, many patients take more than one course. The total number of assignments sent into Boston for correction during this two-year period was 664. It is also of note that of the 83 patients who took

courses, 45 are now either discharged completely or are on visit from the hospital.

Perhaps a few examples will indicate the value to the patient himself of this type of therapy:

R. A. was a man of thirty-five, with a diagnosis of psychopathic personality. At the time when he started his first course, he had just been transferred to the state hospital from a house of correction. His original purpose in taking a course was that he might use some of his time constructively while in the hospital. He completed the course in blueprint and plan reading, consisting of eight assignments. This was followed by blueprint reading for the machine trades, which consisted of sixteen assignments. He spent an hour each week going over the completed assignment with the instructor. His work was always carefully and neatly done, and the grades on his completed assignments were high.

After a short interval, he spontaneously asked for another course of a vocational nature—one that would help him in some work he might do after leaving the hospital. Meanwhile, the social-service department had already made tentative plans for releasing him and placing him in a job in Worcester. The course selected was practical applied mathematics. He completed this, and shortly afterwards left the hospital, a position having been obtained for him in a plate-glass concern.

Several months later the instructor happened to meet him downtown and he said: "You have no idea how much that last course has helped me in my work. In fact I couldn't have done the estimating and figuring that is required of me without it."

Recent reports indicate that this young man has made an excellent work and social adjustment. He has been promoted to the position of assistant manager and is a self-supporting member of society.

L. B., a forty-seven-year-old man with a diagnosis of involuntional melancholia, was a refugee who had been a gynecologist of some note in Bavaria. Early in his hospitalization, he expressed a desire to perfect himself in English. An elementary course called "Plain English" was selected. His progress was somewhat hampered in that he, characteristically enough, felt himself unworthy of any special therapy or attention. However, with shock treatment and psychotherapy, he gradually overcame this idea and did excellent work on his course, continuing with it after his release from the hospital.

M. A. was a woman of fifty years with a diagnosis of manic depressive, depressed. Much of her mental condition was due to the fact that her own children had married and left home, and that her field of interests had been restricted. She chose a course called "Office Procedure for Medical Secretaries"—not with the idea of becoming financially independent thereby, but rather for the purpose of acquiring a new interest which might occupy part of her time after leaving the hospital. She completed this course while in the hospital and started another of an avocational nature—"Landscape Gardening"—before leaving. Shortly after her discharge, she accepted a secretarial position in the out-patient department of a Boston hospital. In this case the purpose of her correspondence course was fulfilled.

The following evaluations of this educational-therapy program have been obtained from various people who hold key positions on the staff of Worcester State Hospital:

Irene<sup>TM</sup> Malamud, psychiatric social worker, in the research service states:

"I do not urge too strongly the establishment of educational therapy programs in our state mental institutions. The addition of a new tool in our efforts to rehabilitate our patients is always cause for excitement and gratitude.

"As a social worker, I have found this new tool invaluable. Its practical use for our younger patients, or for veterans who may thus have the opportunity to secure needed skills, knowledge, and credits to further their educational achievements, needs no emphasis. Perhaps more important is the opportunity offered to stimulate an apathetic mind, to create new interests, and to offer goals to those whose disease has caused them to lose interest in things outside themselves. In the social worker's task of building a social future for her patients, these courses can lighten her work beyond measure."

Evelina Ivany, O.T.R., head occupational therapist, states:

"As an occupational therapist, I feel very strongly that these extension courses are a valuable means of rehabilitation of the patient. Through selected courses it is possible to use the time of hospitalization to advantage, pointing toward vocational adjustment in the community.

"The services of a full-time paid educational therapist would be very helpful in guiding the patient in his selection of courses, and in encouraging and supervising him. The educational therapist, working with the social-service worker and the occupational therapist, could build a very practical program for the patient's means of earning a living upon leaving the hospital."

The nursing angle is presented by Katherine M. Steele, R.N., formerly Superintendent of Nurses at Worcester and author of *Psychiatric Nursing*, now Director of Nursing Services, State Department of Mental Hygiene, California. She says:

"Educational therapy is one of the therapies that should be used in mental hospitals. It is effective with many different types of patient, but I think at the moment of the long-term patient who is benefited not only from the standpoint of rehabilitation, but from the creation of a new interest and a constructive method of self-expression."

And Kathleen C. Coutu, R.N., present Superintendent of Nurses at Worcester, adds her testimony:

"As a nurse, I have observed the interest that the patients have taken in the extension courses. The opportunity that such courses provide for personal contact with the patient is of far-reaching value. I would like to see this program continue and expand."

Dr. William A. Malamud, formerly Director of Clinical Psychiatry, Research Service, Worcester State Hospital, now head of the Department of Psychiatry and Neurology of the Boston University School of Medicine, speaks for psychiatry:

"Any one who has had the experience of working with patients admitted to state hospitals knows that the therapeutic procedures are not limited to the treatment of the disease process itself, but must take into serious consideration the need of keeping a dynamic thread of continuity between the functions of adjustment before admission and those that the patient must assume upon discharge. In keeping this continuity alive, I know of very few efforts that have proven as beneficial as has the systematic plan of educational therapy described by Miss Adams. I have personally followed the work done by her during the years she worked at Worcester State Hospital and have found this plan to be most helpful in keeping the patient's interest in extra-institutional life at its highest and making it possible for him to take up his work outside at a high level of efficiency when he is discharged. I hope that a great many others will follow in her footsteps and make it possible for most of our patients to avail themselves of these opportunities."

In view of the foregoing, perhaps it is not necessary to make any further plea for educational therapy. Perhaps, however, this rather obvious recommendation might be made. If the program is justified, if the results are deemed worth while, it would seem only right that the educational therapist should be given the status of a full-time staff position. The salary, hours, and conditions of this position should compare favorably with those in the field of public education. Only in this way can a state hospital attract to its staff instructors who are equipped both educationally and from the standpoint of psychiatric experience, in a day when the demand for teachers far exceeds the supply.

## BOOK REVIEWS

PROCEEDINGS OF THE INTERNATIONAL CONGRESS ON MENTAL HEALTH, LONDON, 1948. Edited by J. C. Flugel *et al.* Vol. I, *History, Development, and Organization*, 154 p.; Vol. II, *International Conference on Child Psychology*, 142 p.; Vol. III, *International Conference on Medical Psychotherapy*, 129 p.; Vol. IV, *International Conference on Mental Hygiene*, 330 p. New York: Columbia University Press, 1949.

These four volumes present the common denominator of world thinking about mental hygiene in 1948. Professional workers will find little that is new in the 755 pages, but no professional worker should fail to study them in order to appreciate the broad foundation on which mental hygiene rests.

A list of the titles of the fourteen sessions can serve as an outline of present-day psychiatric thinking. The section on "Child Psychiatry" began with "Aggression in Relation to Emotional Development, Normal and Pathological," went on to "Aggression in Relation to Family Life" and "Psychiatric Problems in the Educational Sphere," and ended with "The Community and the Aggressive Child."

The section on "Medical Psychotherapy" began, appropriately enough, with a meeting devoted to "The Genesis of Guilt," went on to "Guilt and the Dynamics of Psychological Disorders in the Individual," and then to "Collective Guilt." This section closed with a session devoted to "Advances in Group and Individual Therapy."

The session on "Mental Hygiene" started with a discussion of "Problems of World Citizenship and Good Group Relations" and went on to "The Individual and Society," "Family Problems and Psychological Disturbances," "Mental Health in Industry," and finally to "Planning for Mental Health."

Volume IV contains the "Text of the International Preparatory Commission Statement." Eager optimists will fail to find what they want in this statement. It is carefully worded, conservative, and designed for world-wide use. It contains no easy guide to mental health. It does, however, set out fundamental plans in relation to human development, to the life of society, and to world citizenship.

The statement also includes recommendations, a list of principles,

an outline for planning, and specific recommendations to the United Nations and the World Health Organization.

No quotation can give an adequate idea of the material in these four volumes, but the following quotation from a summary presented by Professor J. C. Flugel, D.Sc., Chairman of the Program Committee, seems to me to carry the feeling of the entire congress:

"The possibilities and potentialities of mental hygiene depend upon the modifiability of man and human society. In recent times evidence has accumulated from various quarters, but perhaps especially from cultural anthropology, tending to emphasize the immense adaptability of the human mind and of human institutions. The mental-health movement is riding, as it were, on the crest of the wave."

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ORTHOPSYCHIATRY 1923-1948: RETROSPECT AND PROSPECT. Edited by Lawson G. Lowrey, M.D. and Victoria Sloane. New York: American Orthopsychiatric Association, 1948. 623 p.

To review a symposium of more than 600 pages is an imposing task. If more is said here about one paper than another, this is not intended as an indication of their respective merits, but results chiefly from the fact that the papers are of varying lengths and that limitations of space must be kept in mind by a reviewer. Naturally, too, personal interests may lead to more expansive comments on certain contributions. While objectivity in reviewing any book is of course to be desired, as orthopsychiatrists we know that it is humanly impossible to be entirely objective. With this advance apology for its deficiencies, the following review is proffered.

According to Dr. Lowrey, in the last paper in Part I of this symposium, the years 1923 and 1924 were those in which the plan for an orthopsychiatric association was conceived, a constitution formulated, and a decision made to publish a journal—the *American Journal of Orthopsychiatry*. The first annual meeting of the association was held in June, 1924, with nine papers on the program. There were 23 members paying dues that year. Four years later there were 83 members and the three professions of psychiatry, psychology, and social work were represented in this membership. These figures suggest that the growth of orthopsychiatry and of the association was slow at first. That it has been sound is evidenced by the fact that the membership last year, as listed in the journal for October, 1948, was approximately 700.

Lowrey's account of the 1923-1930 period of the Orthopsychiatric

Association's development is preceded by several papers that furnish the historical background of orthopsychiatry. Mrs. William F. Dummer tells about certain experiences that shaped her interest in this field, speaking modestly of her rôle in the start of Dr. William Healy's early work with delinquent children. Dr. Healy and Dr. Augusta Bronner continue the description of their clinical work in a paper entitled *The Child Guidance Clinic—Birth and Growth of an Idea*. The historical material is completed by Dr. George S. Stevenson's account of The National Committee for Mental Hygiene's five-year program of so-called demonstration clinics, and by Dr. Milton Kirkpatrick's report on fellowship training in child-guidance clinics.

The other paper in this retrospective group, Dr. Ben Karpman's *Milestones in the Advancement of Knowledge of the Psychopathology of Crime*, is a little different from the others. Dr. Karpman reviews the literature from 1915 to 1947. He concludes that the research achievements have not been very great except for the advances in a psychodynamic approach to diagnosis and therapy. He stresses the necessity for many more clinics with larger staffs to meet the mental-health needs of the country and to foster more extensive research of higher quality. We can certainly agree that clinics are far too few and their staffs much too small to meet more than a fraction of the human need for their professional services or to permit of anything except very limited time for research.

Part II of the symposium, *Interpenetration of Disciplines*, starts with a brief paper by Dr. Arnold Gesell. He emphasizes the strategic position of the pediatrician, which logically implies that responsibility for preventive mental hygiene rests largely upon pediatric medicine. The relationship between pediatrics and orthopsychiatry is considered more fully in two later papers. Dr. William Langford and Katharine Wickman mention some of the pediatric and psychiatric set-ups that have already been established and discuss the training of the pediatrician from the point of view of giving him a psychiatric orientation. Dr. Milton Senn summarizes current trends in pediatrics and in the education and training of pediatricians.

*Clinical Psychology and Orthopsychiatry*, by Frederick Wyatt, describes three successive phases in the development of clinical psychology in the last twenty-five years: (1) the psychometric phase, focusing on the construction and application of mental and educational tests; (2) the phase of interest in projective techniques; (3) the current trend toward giving the clinical psychologist a well-rounded training in diagnosis, therapy, and research. Dr. Wyatt's explanation of why and how these changes have taken place is thoughtful and well worth reading. So is Dr. David Shakow's evaluation of clinical psychology, in which he explains why Healy had more influence than

Lightner Witmer on the development of clinical work with children and previews the future development of the profession of clinical psychology. Shakow also outlines the four-year plan of training for the Ph.D. in clinical psychology and reports on the American Psychological Association's organization of an American board of examiners in professional psychology.

Morris Krugman's *Orthopsychiatry and Education* is exceedingly practical because of his analysis of the factors that lead to good working relationships between clinicians and school personnel and of those that tend to create misunderstandings and friction. Clinical workers who read this paper may find it helpful in understanding some of their problems in working with schools.

Jules Henry's *Anthropology and Orthopsychiatry* offers suggestions for research on the development of symptoms in children by methods that have been utilized by social anthropologists in other fields of investigation. His statements about the effect of environmental changes upon the child's behavior, illustrated by the child evacuees in England during the war, can be further illustrated by any one who has seen placed children in this country develop behavior problems after loss of their own homes or after a series of placements. Also well worth reading are Henry's discussions of society versus the instincts and of aggression.

Madeline Moore's paper, *Contributions of Orthopsychiatry to Family Case-work*, suggests that case-workers in family agencies have had to carry increased responsibility as a result of what has been learned about family relationships and child development, but mentions a variety of ways of working with family situations to provide better opportunities for the development of children.

H. Meltzer writes on "The Outlook for Orthopsychiatry in Industry." He refers to papers on mental-hygiene work in industrial settings that have been published in the *Journal of Orthopsychiatry* and outlines a program for the application of orthopsychiatric principles to industrial problems.

The final section of Part II consists of three papers on the rôle of the scientist in society. Two of these papers somewhat resemble a debate, in which Dr. Franz Alexander challenges certain uses of financial grants for time-limited, goal-directed research, while Margaret Mead defends this practice. Mead's argument is chiefly economic—the scientist must have funds in order to live and modern research often requires expensive equipment and teamwork. While these economic considerations are real enough, so are the psychological realities emphasized by Alexander, who reminds us that scientific discoveries usually originate from individual creative effort; hence organized research is best adapted to speed up progress in applica-

tions of these discoveries once they have been made. The fundamental disagreement between Alexander and Mead seems to concern the point in scientific development at which financial grants should be introduced if they are to result in the greatest productivity.

Lawrence Cole's paper on the scientist is different from the other two. He paints rather unflattering portraits of the scientist as he sees himself and as Cole sees him. Perhaps these pictures are true, but it may well be that they are colored by emotion—for example, by disappointment that scientists, like other human beings, are imperfect.

The group of papers in Part III deals with functions and practices in the clinical field. Dr. Henry Schumacher's account of the Cleveland Child Guidance Clinic is factual and gives an excellent idea of its operative procedures. Dr. Frederick Allen's paper on the Philadelphia Clinic discusses changes in its approach to helping parents and children, the professional training program at the clinic, and so forth. Simon Tulchin notes that the functions of the psychologist may vary somewhat in different clinics, but he sees the psychologist as a potential participator in diagnosis, therapy, community education, training, and research. Samuel Beck's contribution on the Rorschach test contains extensive references to the literature on that subject. Saul Rosenzweig comments on a number of other projective techniques.

Ethel Ginsburg, writing on the place of social workers in a clinic set-up, where collaboration with psychiatrists and psychologists is necessary, adds a timely warning that case-workers should not become so enamored of the search for emotional problems as to forget reality problems, such as illness, unemployment, and the like.

Dr. Louis Lurie's paper is on the topic of residential homes for problem children, with the Child Guidance Home of the Jewish Hospital in Cincinnati as a concrete example. Lurie also deplores what he considers as too much dependence upon psychoanalytically derived therapeutic techniques and urges eclecticism.

Dr. Margaret Gerard, discussing direct treatment of children, reviews briefly the methods and techniques of Anna Freud, Aichhorn, Allen, Gitelson, Levy, Conn, Solomon, and others, before presenting some of her own views and illustrating them with three case summaries. Lowrey speaks of the outstanding trend of the last fifteen years in child guidance as the interest in therapeutic techniques and discusses the types of therapy developed, including group therapy. His material supplements Gerard's very nicely.

Nina Ridenour makes practical suggestions for mental-hygiene education, including the use of such media as the press, radio, and drama.

Part IV is a reprinting, in somewhat condensed form, of three papers on treatment by Dr. Samuel Hartwell, Charlotte Towle, and Simon Tulchin, originally read at the 1930 meeting of the Ortho-

psychiatric Association and published in the October, 1930, issue of the journal.

The volume ends with short biographical sketches of the authors.

How to appraise all this material is a question. Undoubtedly, readers will not find all the contributions equally interesting, but will be influenced by the background brought to the reading. For instance, any one who has been working in child-guidance clinics since their beginnings in 1922 may regard the historical section as very largely familiar territory, but younger workers in the field may consider it more informative than the discussions of recent trends which have developed in their own time. Again, the psychologist may be inclined to read the papers written by members of his own profession more carefully than others; similarly psychiatrists and social workers may be most intrigued by the authors representing their respective professions. It is hoped that this review, although giving no more than a bird's-eye view, may stimulate interest in reading, if not all of the papers, at least a great many of them.

PHYLLIS BLANCHARD.

*Philadelphia Child Guidance Clinic.*

A DECADE OF GROUP WORK. Edited by Charles E. Hendry. New York: Association Press, 1948. 189 p.

This small volume is a compilation of brief surveys of group work in various fields. Of the twenty-three brief chapters, sixteen describe group work as a method in camping, recreation, physical education, child welfare and therapy, intercultural, religious, adult, and workers' education, housing projects, institutions of higher learning, short-contact services, war time, industry, and personnel management.

Other chapters deal with the literature in the field, with research and the history of this endeavor.

The volume is intended to mark the tenth anniversary of the founding of the American Association for the Study of Group Work, an event that occurred in 1938. The aim is to review the backgrounds and developments during the decade in which the association has functioned. The present American Association of Group Workers had emerged from its predecessor, the study association, which itself succeeded the New York Conference on Group Work, organized by Joshua Lieberman, some years prior to the founding of the study association.

It is obviously difficult to evaluate a work of this nature, which has twenty-five contributors and one hundred or more "consultants." Each chapter was written by one person, but represents the thinking of a group which was responsible for it. The book should be of

great value to persons interested in group work, and particularly to students who wish both to learn the background and to gain a wider view of the subject and what it has to offer in a democratic social setting. The book mirrors what has occurred and is occurring in group work, and should, therefore, prove of the utmost value both to novices and to experienced workers. It is highly recommended as an historical as well as a contemporary review of the subject.

S. R. SLAVSON.

*Jewish Board of Guardians, New York City.*

THE PSYCHOLOGY OF BEHAVIOR DISORDERS, A BIOSOCIAL INTERPRETATION. By Norman Cameron, M.D. Boston: Houghton Mifflin Company, 1947. 622 p.

In recent decades, attempts have been made to relate the subject matter of the two sibling disciplines, psychology and psychiatry. The proponents of these disciplines have suffered from sibling rivalry and mutual distrust and are frequently brought together because of a sincere regard for the common progenitor—the problems of the human mind. From a practical point of view, this disharmony between the two disciplines has been less evident in the clinic and in the hospital than in polemical writings. It is chiefly when one attempts to unite these approaches in theory and still keep in view accredited clinical facts and observations that one senses the strain induced by the ambivalent feelings of psychology and psychiatry for each other. Within this area of tension, Professor Cameron has set about in a workmanlike manner to try to unite observable behavior and behavior pathology with a theory of mental functioning. The result is a stimulating work.

Professor Cameron is an indoctrinated psychiatrist and a trained psychologist who now holds a chair in the departments both of psychiatry and of psychology at the University of Wisconsin. His presentation of neurosis and psychosis—i.e., of behavior pathology—is from a consistently biosocial point of view. His view is holistic and deals without benefit of psyche with reactions of the biological organism to its social environment as these reactions stretch from those that are “normal” to those that are “abnormal.” The personality, then, is considered as a dynamic organism of interlocking behavior systems developed through learning processes as the individual passes through the intimate family group to the larger social environment. The author feels that, in this type of thinking, he has escaped the obstacles of the psychosomatic dualistic approach, has evaded concern with consciousness and the ego, and has come

face to face with a workable theory of human activity couched in biosocial terms.

In this way Professor Cameron has developed a consistent psychiatry. Although the title of the book embodies the term psychology in it, Professor Cameron repeatedly repudiates the concept of *psyche*, including all the ramifications that ego psychologists have observed or have read into human behavior. In the clinical section, for example, he does describe observable activities of the ego or the personality, but considers them as merely exaggerated or minimized expressions of the original biosocial bent of the developing individual.

The early part of the book provides a comprehensive statement of the growing experience of the child, with biosocial reactions from infancy on, as they form on the basis of emotional reactions, language development, thought evolution, and the process of rôle-taking in the social community. Professor Cameron shows how these facets of the personality come into conflict with the environment and develop the familiar frustrations and conflicts as the personality adjusts to change in its environment.

The second two-thirds of the volume deals with the biosocial analysis of common nervous disorders (behavior pathology) such as hypochondriasis, fatigue syndromes, anxiety disorders, hysterical difficulties, schizophrenic reactions, and the so-called organic disturbances. The volume closes with a chapter on therapy as biosocial behavior.

Professor Cameron is strongest in the early section of the book, as he develops the thesis that human reactions move from the simple to the complex in accordance with early biosocial patterns. He shows how attitudinal patterns develop in relation to early contacts with the mother, and "it is this temporal extension of attitudes, which prepares a behavioral background in advance of the appropriate responses" in later life. This development is likewise carefully etched out in the various behavior pathologies.

The relationship between normality and abnormality is quite clear; for example, in hysteria, inactivations in the body occur where extremes of overexclusion occurred in normal behavior. In the latter, exclusions of outside stimuli are necessary for adequate function. It is a commonplace that to drive a car one must exclude many irrelevant reactions; similarly in hysteria such exclusions reach the extreme point of paralysis or anaesthesia.

Each clinical entity is developed from this base line of biosocial patterning and examples are given profusely. The methodology employed poses the question in the case of each neurosis (as, for example, hypochondriasis), "What determinants are there that seem

to favor the development of body overconcern in those individuals who do become hypochondriacal?"

In this structured psychopathology, the author hews closely to the psychobiological view of human activity, and in so doing succeeds in renaming rather than in rethinking many concepts that clinical psychiatrists and analysts have found invaluable. In the course of reading this book, the reviewer became conscious of a growing admiration for the author's tenacity in holding to his purpose of re-writing a behavioral, but not behavioristic, psychiatry. At the same time, one was aware of an irritation at his insistence on renaming syndromes and feeling reactions already adequately described and worked through. For example, the hysterical affective split-off is called *overexclusion* (p. 58); identification is called *rôle-taking* (p. 309); and the myth of royal birth, or the myth of the birth of the hero, is called *Mignon delusion* (p. 402). The accepted Krapelinian division of schizophrenia into four types is redivided into three groups with their subdivisions as the (1) *aggressive schizophrenic reactions (persecuted, grandiose, and self-punitive)*; (2) *submissive schizophrenic reactions (compliant, dedicated, and transformed)*; and (3) *detached schizophrenic reactions (avoidant and adient)* (p. 469). Narcissistic investment is called *body overconcern* (p. 203). And so on.

Undoubtedly this volume will help the student to attain an understanding of the similarities between normal behavior and so-called psychopathology and herein lies its greatest virtue. The author is careful to relate behavior techniques like repression to recognizable behavior reactions, such as exclusion, required in earlier or later life for performing any social function, rather than to any "mythical" concept like the "unconscious." This approach removes the necessity of thinking in terms of conscious or unconscious activity in considering basic adjustive techniques (habitual methods) which humans use to avoid, overcome, or escape from frustrations and threats.

In the main, this appears to be a fruitful method of thinking, but in situations such as anxiety disorders, this derivation of behavior pathology sidesteps an area into which psychoanalysts plunge. The explanation provided seems to this reviewer to be too simplistic. For example, the author indicates that old *anticipant* attitudes acquired in childhood may make a person reaction-sensitive in later life or on proper provocation. A man who develops a panic on seeing death or a deceased person does so because anticipant attitudes are aroused as a result of his having witnessed, in early life, "funerals, or hearing and reading about ghosts, corpses, murders, premature burials and body-snatchers."

What Professor Cameron neglects is the specific emotional meaning, in terms of the individual's emotions and reaction-formation, of such stimulation. In other words, the author begs the question of what makes such experiences anxiety-producing in the given individual, in terms of his own fantasy experience or unconscious participation in the experience.

The chapter on behavior disorders and cerebral incompetence is enlightening and stresses very clearly the newer attitude toward maladaptation in cerebral incompetence—namely, that the organic psychosis is a reaction to a handicapped personality rather than a disease due to the effect of arteriosclerosis or brain tumor on cerebral tissue.

In the chapter on therapy, the views of biosocial adaptive or maladaptive techniques are brought together for therapeutic consideration. Here the author describes the permissive attitude of the therapist, discusses the rôles of patient and therapist, and clearly indicates how patients' self-reactions are brought to the surface, thereby permitting the patient to talk through and live out "the behavioral antecedents and implications of his self-reactions along with those of the rest of his reactions in the therapeutic situation." In this, however, Cameron skirts a discussion of transference phenomenon with its psychotherapeutic implications. Throughout his treatment of therapy, the author carefully analyzes the meaning of the permissive attitude in a biosocial situation without stepping over the line into an investigation of what this biosocial relation means to the ego, the executive agent of the total personality.

The volume does not discuss psychopathic personality or the neuroses of childhood among the clinical entities to any extent and there is little mention of psychosexual disabilities, so prominent in the complaints and productions of psychotic and neurotic patients. Although the author does not neglect the sexual aspects of personality development, he does, in this reviewer's opinion, minimize them, as judged by actual utterances of patients when treated in the permissive manner so well outlined by the author. Nor is any serious attention given to dreams, but that is to be expected from the total orientation of the work.

To summarize Cameron's contribution, it may be said that his fresh viewpoint is of value as a basic indoctrination in passing from psychology to psychiatry, from normal behavior to abnormal behavior. In this, it is of great value to the student of psychology and psychiatry. It is a viewpoint that is indeed a base line for operations. By the same token, it does not allow a view of all the nuances and movements in the bewildering structure of human psycho-

pathology. The journeyman in the therapeutic field of behavior disturbances requires more than a sketch. He needs to grapple with materials of such stuff as the ego is made of.

WALTER BROMBERG.

*Reno, Nevada.*

FAMILY, MARRIAGE, AND PARENTHOOD. A SYMPOSIUM. Edited by Howard Becker and Reuben Hill. Boston: D. C. Heath and Company, 1948. 829 p.

According to the editors, the above volume is an outgrowth of an earlier symposium, *Marriage and the Family*. It is a new book rather than a revision, although five of the old chapters have been retained. As a textbook, this volume has been "designed to make tested knowledge available and assimilable," but it is not expected that it will appeal to the immature. Family, marriage, and parenthood are regarded as "webs of social interaction" and because "most of the specialists dealing with social interaction are sociologists, or social and cultural anthropologists," most of the authors of the twenty-six chapters have been recruited from these groups. Although brief, passing reference is made to a number of authors in the mental-hygiene field, this is often for the purpose of indicating that the problem can be more simply explained by sociological concepts. Because mature students inevitably seek help with or answers to their own problems, an attempt has been made to combine analyses by specialized sociologists with the "problem-solving talents of the social technologist."

In Part I, *Contexts of Family Life*, Howard Becker lists seven functions of the family: reproduction of population, protection and care of the child, education and socialization of the child, economic production of family goods and services, and recreation and affectional interaction. One of the major forces that result in instability of life and personality to-day is the rapid movement away from the sacred, traditional, or folk societies, with their isolation, their close integration in kinship and neighborhood groups, and their time-honored customs and great resistance to change. In secular societies, chiefly urban, old customs and sanctioned values have broken down; individualism, anonymity, and a trend toward expediently rational thinking and action predominate, resulting in accelerated readiness for change. The analysis and description of seven types of personality that emerge in a rapidly changing society will be of interest to mental hygienists: unadjusted or amoral; maladjusted or demoralized; partially adjusted or segmented; in-between adjusted or marginal; uncritically adjusted or regulated; fretfully adjusted or decadent; and tight-rope adjusted or liberated. The historical evolution,

the variety of family patterns and the forces that have influenced the family and the position of women to-day are concretely illustrated by excellent brief, vivid descriptions of family life in various historical periods and countries.

In Part II, *Preparation for Marriage*, mental hygienists may be interested in the carefully prepared chapters, *Producing Marriageable Personalities*, *Steps in Love and Courtship*, *How Mates Are Sorted*, and *The Engagement: Thinking About Marriage*.

In Part III, the problems of marriage interaction are rather meagerly covered in two chapters, by the same author—*Getting Along in Marriage* and *Discords in Marriage*. Marriage is regarded as "essentially an affectional relationship which has its beginning far back in the earliest affectional experience of the child in his family." It marks "the culmination of the affectional maturation process which was initiated in the cradle." Of great importance to adjustment in marriage are the "total life organizations of the individuals concerned." Some persons "are better able than others to meet the series of situations which marriage initiates because they have already developed a life organization which provides them with workable adjustment practices." The individual "attempts to adjust himself to the demands of marriage in the same way he has adjusted to previous crisis situations" and "if these practices are ill adapted to the special problems of marriage, conflict is inevitable."

In Part IV, *Problems of Parenthood and Family Administration*, mental hygienists will be charmed by a beautifully written chapter on the opportunities of parenthood. In Part V, *Family Crises and Ways of Meeting Them*, there are two chapters, by the same author, on handling family strains and shocks, and bereavement, and a third chapter on the scope and meaning of divorce. Three chapters in Part VI analyze the effects of war on family life, population problems, and plans for strengthening family life. Scattered through the various sections of the book are some practical chapters on financing marriage, the anatomy and physiology of sex and sex relations, heredity, the care of mother and child before and after birth, designing and running the family home, and the relation of law and religion to family life.

To judge by the frequency of references to their writings, a few authors have exerted great influence on the thinking of many of those who contribute chapters to the book. Sociological studies by Howard Becker, University of Wisconsin, and his associates, are frequently cited. Three books by Willard Waller—*The Family: A Dynamic Interpretation* (1938), *War and the Family* (1940), and *The Old Love and the New* (1945)—are referred to by many authors.

The publications on family life by Joseph K. Folsom also seem to have had influence. The favorite mental-hygiene publication was the book by John Levy and Ruth Monroe, *The Happy Family*, published in 1938. Great weight has been given by many of the authors to two research studies: *Psychological Factors in Married Happiness* (1938), by Lewis M. Terman and associates, and *Predicting Success or Failure in Marriage* (1939), by Ernest W. Burgess and Leonard S. Cottrell, Jr. Some references are also made to Gilbert V. Hamilton's *A Research in Marriage* (1929); to *A Thousand Marriages: A Medical Study of Sex Adjustment* (1931), by Robert L. Dickinson and Lura Beam; and to Katharine B. Davis' *Factors in the Sex Life of Twenty-Two Hundred Women* (1929). In the appendix is printed a copy of the marriage prediction scale by Ernest W. Burgess and Leonard S. Cottrell, and an engagement adjustment scale by Ernest W. Burgess and Paul Wallin. At the end of each chapter is a generous list of selected readings, followed by a well-worked-out list of topics for discussion or reports.

CLARA BASSETT

*New York City.*

PSYCHIATRY IN NURSING. By Raymond Headlee, M.D., and Bonnie Wells Corey. New York: Rinehart and Company, 1948. 308 p.

In their preface, the authors state that they prepared this textbook to meet "the special requirements of the psychiatry affiliation program." In the next paragraph they state that "although the broad outline of the book follows traditional patterns—normal, the deviations from the normal, the nurse's attitude toward her patients, and her responsibilities—actually the text breaks with tradition in several ways. The most important of these is the attempt to treat the nurse as a mature, responsible person."

The table of contents is divided into three parts. The first, consisting of four chapters, deals with normal variations in human behavior; the second, ten chapters, is devoted to the varieties of mental illness; the third, four chapters, presents the practice of psychiatric nursing. In addition, there are three appendices and an index.

The number of textbooks prepared for nurses on the subject of psychiatry is, at present, large. Evaluation of a given text must include comparison with its predecessors. *Psychiatry in Nursing* suffers in some respects by such comparison. To mention a few instances, as noted by the reviewer, the variety of subjects included is extensive; consequently each is presented too briefly to be satisfactorily comprehensive. The classification of diseases is according to causes and behavior, which necessitates frequent repetitions. The authors note this fact in several places. On the other hand, there are omissions,

chiefly items that might have value to the nurse in dealing with psychotic patients. For example, in the chapters dealing with pain and sleep, nursing measures that might be helpful to relieve pain and induce sleep are not mentioned. Among the therapeutic measures mentioned, prolonged narcosis is omitted. This is a therapy that depends for success in great measure on the skill of the nurse involved. In a modern textbook for nurses, it might be included advantageously.

In the opinion of the reviewer, the chapter on sexual adjustment could be omitted to the advantage of the text, since the subjects discussed are presented in too elementary a manner to be informative to a modern young person accustomed to the sophisticated presentation of emotional behavior disturbances in the newspapers, magazines, movies, radio, and theater of the day. The suggestion that homosexuality may be hereditary (p. 47) is questionable. Should a young, inexperienced student nurse accept the suggestion offered on page 29 that "she may be called upon to advise, working through the wife," on the subject of impotence? She may do more harm than good. The psychiatrist may prefer to do the advising.

The chapters devoted to the practice of psychiatric nursing are brief and somewhat vague and less complete than is desirable. The appendices, however, contain useful study hints. An outline for case history should be helpful to a student nurse. The bibliography is impressive in the number of books listed and their classification.

The phraseology of the text is occasionally awkward—for example, the phrase previously quoted from the preface, "requirements of the psychiatry affiliation program." Some phrases appear to be unduly defensive. For example, the opening paragraph of Chapter 5, dealing with infections, reads: "No social stigma is placed on the victim of pneumonia or of scarlet fever. Why, then, should it not be recognized that social condemnation, either explicit or implicit, of patients in mental institutions is grossly unfair, particularly so when the cause of their dementia is an infectious disease, such as Rocky Mountain spotted fever, syphilis, or encephalitis?" The origin of syphilis differs in some respects from the other two conditions mentioned, which makes a bracketing of the three seem inappropriate.

The text appears to have been designed to accompany a series of lectures and classes organized for the student at a particular hospital. Presumably it was supplemented by lectures, clinical demonstrations, and discussions. It may be of considerable value in the situation for which it was prepared. Instructors in psychiatric nursing in other institutions may need to supplement it with other texts.

MARY E. CORCORAN.

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Health Service, Washington, D. C.*

REHABILITATION OF THE PHYSICALLY HANDICAPPED. By Henry H. Kessler, M.D. New York: Columbia University Press, 1947. 274 p.

Written by an outstanding leader in the field who has had long and extensive experience both in military and in civilian aspects of rehabilitation, this book covers the broad principles that govern the modern approach to the vocational readjustment of handicapped persons. According to the new dynamic standpoint, physical handicaps are defined in social and economic rather than medical or anthropologic terms. The emphasis throughout this book is on the productive capacities, potentialities, and reserves in every individual, regardless of physical defect. Rehabilitation is defined as an organized and systematic method by which the remaining physical, mental, and vocational powers of the individual are utilized and developed to their highest efficiency. In the author's words, physical disability has no meaning except as it refers to what an individual does to solve his own problem, and what private and public agencies will do for him in easing that problem.

Traditional attitudes and prejudices constitute the most serious obstacle to progress in rehabilitation work. Past estimates of physical fitness have not been made on scientific grounds, and existing statistics on the number of individuals with physical handicaps are unreliable and misleading. Despite all evidence, the popular belief that the disabled are economic liabilities, that they are accident-prone, and that they represent special employment hazards, has still to be dispelled. The basic need, according to the author, is to regard the disabled as individuals, not as a dependent class, and emphasis must be placed, not on the degree of dependence, but on ultimate vocational adjustment.

Discussion of the various types of handicap in the book follows the customary social and legislative classification: the crippled child, the injured worker, the disabled veteran, and the chronic disabled. Education for the crippled child must be twofold—education for life, and education for earning a livelihood. Compensation laws frequently fail to realize their major aim, the restoration of the injured worker to gainful employment. Although the trends in the general practice for readjustment and rehabilitation of the war disabled are encouraging, the present system still permits veterans to seek security in pensions instead of in gainful jobs. The chronic disabled group includes the congenitally deformed adults, highway-accident victims, chronic invalids, and the aged. The author's discussion of the aged is the least hopeful, and is limited to but two pages.

Although the principles of vocational guidance are the same for the physically handicapped as for so-called normal individuals, here

the aim is even more "to introduce rationality in the place of intuition, and fact for chance, in making the choice of a job objective." Numerous case illustrations, drawn from the author's clinical and military experiences, are interspersed to show the importance of each step of the rehabilitation process. In practice this consists of medical care devoted to physical restoration, vocational guidance, vocational training, and finally selective placement in employment.

This same sequence is emphasized in each of the succeeding chapters, which are entitled, respectively, *The Mentally and Emotionally Disabled*, *The Orthopedic Patient*, *The Blind and the Deaf*, and *Medical and Surgical Invalids*. Although the discussion of the mentally and emotionally disabled is limited to broad generalizations concerning the employability of psychotic, psychoneurotic, alcoholic, epileptic, and neurologically diseased patients, a cautiously hopeful outlook is offered when rehabilitation services for these patients follow the pattern of other types of disability.

The value of the book is greatly enhanced by the author's forthright style and his vigorous attack on entrenched prejudices and misconceptions concerning the physically handicapped. The fearlessness with which he presents his own personal views is shown by his summary dismissal of Sheldon's work, and his endorsement of a compulsory universal health record for every individual in the country, to be kept on file in the state departments of health. This in no way detracts from the value of the book as an introductory guide for physicians, nurses, and occupational and employment counselors to the principles of rehabilitation. No one who reads the book, whether layman or professional worker, can fail to be inspired by the author's sound philosophy as applied both to the understanding and to the therapy of physically, mentally, and emotionally handicapped individuals.

LEONARD E. HIMLER.

*University of Michigan, Ann Arbor.*

UNITS IN PERSONAL HEALTH AND HUMAN RELATIONS. By Lillian L. Biester, William Griffiths, and N. O. Pearce. Minneapolis: University of Minnesota Press, 1947. 267 p.

One of the most vigorous and most rapidly growing siblings in the curricular family is education for marriage and family life. Student demand for such education is widespread. Faculty interest is increasingly turning in this direction. There is no longer any doubt that this type of education is here to stay—more than that, it must stay. On the other hand, there is a serious doubt, amounting sometimes almost to a fear, expressed in one way or another in

questions concerning personnel. Where can we find enough teachers sufficiently well prepared to do the job that needs to be done?

There is no simple, ready-made, capsule answer to that question. There is no quick-and-easy way fully to prepare even the most interested instructors. But there are means of furthering the preparation of such persons. The book under review is a significant contribution toward this end. It could play a part not only in improving an instructor's work, but also in giving him greater self-confidence in plunging into a relatively new field where guideposts are few.

The book is designed as an aid to teachers on various levels. Chapter headings, such as *How Do Living Forms Reproduce?*, *How Does Heredity Affect Human Life?*, *How Can We Develop Happy and Wholesome Relationships with People of the Other Sex?*, *How Can We Make Our Marriage Happy?*, *How Can the Family Work Out Satisfactory Relationships Among All Its Members?*, give an idea of the areas covered. In connection with each topic there is a discussion of objectives, time required, teaching procedures, sample approaches, questions for study, suggested student activities, sources of information, evaluation, tests, bibliography, technical terms, answers to questions that students frequently ask, and visual aids.

Any instructor in the broad area of education for marriage and family life may read this book with profit. The instructor not too sure of his background, not too certain of how to approach various topics, not too confident that he can answer student questions, not too familiar with source materials, will find that this book will aid him to reach a point in the organization of his program which without the book he would have to reach by trial and error and considerable "spade work."

The book has one not too serious weakness. Topics are arranged as if each one were presented to students on a different age and educational level, thus making for a planned sequence from kindergarten through junior college in an integrated program. Unfortunately, relatively few teachers operate within such a program. Most instructors must take their students where they find them; and often an instructor is the only one in an entire school who is attempting to do anything in this area. College teachers, for instance, often find students ignorant of facts they should have had contact with years before. This weakness does not vitiate the value of the book. It will, however, make necessary some adaptations by teachers of older students. Such adaptations can readily be made by the instructor who exercises ingenuity.

HENRY BOWMAN.

*Stephens College, Columbia, Missouri.*

MARRIAGE AND THE FAMILY. By Meyer F. Nimkoff. Boston: Houghton Mifflin Company, 1947. 767 p.

This book is more than a mere revision of the author's earlier work, *The Family*, published in 1934. It is essentially a new work. The older book was devoted to the family as a social institution. The present volume is much more elaborate; it attempts to combine into one text two objectives that are often the subjects of separate texts and college courses. These are (1) the sociology of the family, or the family as a social institution, and (2) materials and suggestions that might be useful to the student in preparing him for marriage and parenthood.

The book is divided into four parts. There is an introduction consisting of three chapters—*Organization of the Family*, *The Family and the Evolution of Material Culture*, and *Backgrounds of the Modern American Family*. These deal with the family as a social institution and trace the variations that occur from one culture to another. Part II, consisting of six chapters, is entitled, *Modern American Family and Culture*. It is devoted to an analysis of contemporary family organization in the United States. Rural and urban differences are noted, as are regional variations and differences according to income, occupation, social class, and ethnic group. There is a chapter on "The American Negro Family."

Part three, *Marriage and Personality*, contains chapters on "Courtship," "The Choice of a Mate," "Prediction of Marital Happiness," and "Parents and Children." The emphasis in much of this section is on factors that tend to shape personality. Part IV, *The Family and Social Change*, contains chapters on "The Changing Modern Family," "Family Disorganization," "Family Reorganization," and "The Happy Family."

A central thesis running through most of the work is to the effect that "scientific inventions and discoveries, especially those related to the means of production and embodied in technology, are the most influential factors in social change and furnish the principal key to an understanding of the prevailing patterns of family organization" (p. ix). It is argued that developments growing out of the Industrial Revolution have resulted in the gradual loss of many of the traditional functions of the family to such agencies as industry and the state. This has further resulted in marked accentuation of the residual affectional functions. The author views the family as now being "the great agency concerned with the problem of human happiness." For this reason the last half of the book is devoted essentially to the problem of finding happiness in marriage.

Some will probably feel that the author has overemphasized the

importance of economic and technological factors in influencing family change. Others may perhaps feel that undue emphasis has been placed on individual happiness as a goal for successful family life, to the exclusion of such factors as social responsibility to society.

The work is excellently illustrated with helpful charts and photographs. There are 121 charts or graphs, 18 plates, and 34 tables. At the end of each chapter are lists of questions for discussion, topics for report, and selected readings.

In the opinion of the reviewer, the author has written an excellent text for college students and a useful reference work for laymen as well.

N. L. WHETTEN.

*University of Connecticut.*

YOUR BABY. By Gladys Denny Shultz and Lee Forrest Hill, M.D.  
Garden City, N. Y.: Doubleday and Company, 1948. 278 p.

For parents facing life with a new baby, this book should be invaluable. It has many features to recommend it. Not the least of these is its point of view, which places the baby directly in the laps of *both* parents. The satisfactions and responsibilities of fatherhood are high-lighted from the first chapter, which is entitled, *We Are Pregnant*. Fathers are encouraged to enjoy a full share in planning and anticipation and later to lend a hand with bathing the baby, feeding, and even taking over some of the household tasks where possible.

The style of this book is informal—almost intimate—and the tone is reassuring. The subject matter is simply stated and well organized. Frequent marginal topics make it easily accessible. Care, feeding, and development during the first two years are covered in considerable detail. The period through the fifth year is handled more generally and includes some helpful ideas for guiding the child's social progress. One of the outstanding sections of the book is the chapter on techniques of baby care. Picking up, handling, dressing, bathing, feeding, and so on, are not only discussed in full, with step-by-step directions, but are illustrated with drawings and well-chosen photographs.

Emphasis from beginning to end is on normal growth and development, with just enough attention given to possible variations from the normal to point up the value of individual medical supervision.

The final thirty-three pages are planned as a record of the baby's progress in all fields from birth to school age, with spaces for photographs and comments from both parents.

DOROTHY E. HALL.

*Infant Welfare Society of Chicago.*

THE HAPPY HOME: A GUIDE TO FAMILY LIVING. By Agnes E. Benedict and Adele Franklin, with an introduction by Benjamin Spock, M.D. New York: Appleton-Century-Crofts, 1948. 304 p.

Here at last is a new kind of book for parents. It is written by two well-known educators; Agnes E. Benedict has published a number of books on modern education and Adele Franklin is director of the All-Day Neighborhood Schools in New York. They not only know and care about children, but they also sympathize with and understand parents. They are, therefore, able to offer help to mothers and fathers in the actual home situation. It is really astonishing to discover, under the guidance of the two authors, how exciting the daily experiences of living can become for parents as well as children.

Here is how Miss Benedict and Miss Franklin describe the purpose of their book:

"This is to be an adventure in family living in the home itself. . . . Its protagonists will be the entire family: father, mother, children. In fact the family will become, in a sense, a single personality, a living organism, made up of separate parts, which have lives of their own and are developing in their own ways, but which at the same time are synthesized."

This is no solemn text, but a straightforward talk to parents on how to make family living easier, happier, and more creative. The strength of its method lies in its practical suggestions and its avoidance of theoretical generalizations. For every shared experience of the family, it has suggestions that can expand the horizons of parents as well as children.

The note struck in the first chapter on the subject of recreation is vital to the creation of sound family life. "We propose," say the authors, "to replace some—not all—of our passive recreation—motion picture, the radio, the automobile, as well as baseball games, plays, and concerts—with active recreation which we ourselves seek and grasp and make our own." That is a magnificent statement, striking at the weakness in the American approach to recreation and play. And yet how many parents in this country to-day would understand what was meant by shifting from "passive" to "active" recreation? Not a few would say, "We don't understand. What else can we do with our children, to have fun, but listen to the radio or go to a movie or take a drive in the car?" If they really want to know, here is a book to tell them how they can make playtime more worth while for everybody in the family.

For parents who had always assumed that they had to make the decisions about such important matters in family life as vacations, home decorations, and perhaps even the selection of their children's

clothes, here are some illuminating suggestions on how to encourage initiative, taste, and responsibility in growing children.

But the authors are under no illusion as to the limitations within which children are able to carry responsibility. They place on the shoulders of the parents the responsibility of leadership in these words:

"Parents are the leaders in the democratic home. . . . If at any time the parents fail to exercise leadership, or if there is the slightest doubt in the children's minds about the matter at any time, confusion will result. . . . To administer a home democratically, however, parents must have faith in children. . . . Just as you need to believe in yourself, so children need your faith in them—in their intelligence, in their innate fairness, their consideration, their capacity to act wisely. . . . And we must be absolutely frank with them; they must know exactly what is to be decided for them and what they are to decide for themselves. When we do help them decide, we must decide *with* them, not *for* them."

A brief survey of what is touched on in some of the chapters will suggest the breadth and practicality of the book. One chapter deals with the management of the home, with special emphasis on the planning for privacy for children as well as adults. Another chapter deals with the ways and means of making use of conversation between children of varying age-levels and their parents in order to build up an *esprit de corp* in family life. Other sections of the book treat of ways that the entire family can find to share their varied interests and activities. These suggestions include games, excursions, scientific experiments, and creative expression through all the arts. In another section parents are made to realize how their own professions and hobbies can be made of interest to their children as well as to themselves.

A glance at the carefully selected bibliography will be a joy to parents, for it offers a mine of supplementary information as an aid in putting the authors' suggestions into practice. Reference books are grouped under such headings as *Art, Creative Writing, Crafts and Carpentry, Music and Dancing, Games and Parties, Gardening, Holidays and Festivals, Nature, Pets, and Science*. Also listed is a group of books on such subjects as ancient life, astronomy, aviation, and sports.

In the concluding section, the bibliography contains books for parents on the physical growth and the emotional problems of children. But one misses any corresponding discussion of the emotional problems of children and parents in the body of the book. Why have the authors not included a chapter on the emotional conflicts in normal family life—on the emotional tensions between parents and children and between the various children of a family? For that is an aspect of family living in which all parents need a helping hand.

*The Happy Home*, with the exception of this single omission, within the compass of its three hundred pages, surpasses, for the use of parents, most of the technical tomes on childhood growth and development. Certainly Miss Benedict and Miss Franklin have, in this book, offered imaginative assistance to those searching parents who really want to develop the art of living with their children.

MARGARET NAUMBURG.

*New York City.*

STUDENT PERSONNEL SERVICES IN GENERAL EDUCATION. By Paul J. Brouwer. Washington, D.C.: American Council on Education, 1949. 317 p.

At first glance, the title did not seem too intriguing—many have written on this and that phase of student personnel services and education—and so I picked up the book casually. Before I knew it, I was engrossed in it, jotting down ideas and expressions, checking against them my philosophy of counseling and the policies in a student personnel setting. I read the last chapter, *An Outline of a Personnel Philosophy of Education*, twice and expect to read it again. While the major assumptions may leave “many issues unclear” because of their generality, the chapter is extremely useful to those groups which are “exploring the meaning of a personnel point of view or are interested in digging below the surface of personnel practices to their bases in attitudes toward human nature, society, and the work of education.”

The book itself is the outcome of a five-year cooperative study in general education sponsored by the American Council of Education. The objective of the study was a survey of educational practice—a scrutiny of what was being done, what could and ought to be done, and how desirable changes could be effected. The finished report was set forth in four volumes: (1) *General Education in the Humanities*; (2) *General Education in the Social Studies*; (3) *Student Personnel Services in General Education*; and (4) *Coöperation in General Education*.

The book in review, the report on student personnel services in education, is divided into three parts. The first, *Developing the Personnel Services*, covers such topics as counseling, the process and the program; the educative value of extra-class life and living arrangements; pre- and post-college personnel services; specialized personnel services; administration of personnel services; and so on. The second part deals with facilitating the personnel services, and the third takes up the principles of personnel services, under the headings of psychological, physiological, philosophical, and sociological principles.

The emphasis throughout is upon “a unified program of student

personnel work as an integral part of the program of general education aimed at the *total development* of each student," and the ways in which this can be effectively accomplished. The report examines various methods of discovering, identifying, and meeting student needs through "the coordinated use of fact-finding devices and of personnel services." It affirms that all those who "influence the educational experiences of students are personnel workers." It is, therefore, written with a view to making it a practical, thought-provoking reference book for all who work with college students—whether it be in the capacity of teachers, counselors, administrators, or parents—and for the students themselves.

The book is well written and well organized, and has much to offer that is challenging and searching. It is simply enough presented for the untrained individual, yet stimulating to the worker on the job and to the specialist. Case histories, illustrations, and charts are well selected, telling, and to the point.

I like the feel of having *Student Personnel Services in General Education* on my bookshelves for my own frequent reference or to be shared with others in formal and informal talks. It is an incentive to further thought and study. One cannot but wish that Mr. Brouwer had included a selected bibliography to supplement the material and to help clarify and make more explicit some of the issues in individualized education. But even without this, it is a top-notch book.

ESTHER M. DIMCHEVSKY.

*University of Denver, Denver, Colorado*

## NOTES AND COMMENTS

### SECOND MENTAL HEALTH ASSEMBLY OF WORLD FEDERATION FOR MENTAL HEALTH

The World Federation for Mental Health held its Second Mental Health Assembly in Geneva, Switzerland, August 22-27, 1949. Approximately forty Americans, representing the United States membership in the World Federation for Mental Health either as delegates or observers, attended the meetings. Dr. Leo H. Bartemeier and Miss Esther Heath acted as chairman and vice chairman, respectively, of the United States delegation.

Officers elected at the assembly included the following: President, Dr. André Répond, Switzerland; Vice President, Dr. William Line, Canada; Honorary Secretary, Dr. Kenneth Soddy, England; Acting Treasurer, Dr. M. K. el Kholy, Egypt; Director-general, Dr. J. R. Rees. Dr. George S. Stevenson, Medical Director of The National Committee for Mental Hygiene, remains as a member of the executive board, and Dr. Leo H. Bartemeier, of Detroit, has been appointed to the executive board as an alternate.

Twenty-one countries were represented at the assembly. The work of the conference was accomplished through working parties, which considered professional education in mental health, public education, rural mental health, student mental health, mental-health aspects of education with particular reference to education in Germany, religion, international relations, displaced persons, and scientific research.

### JOSIAH MACY, JR., FOUNDATION TO CONTRIBUTE TO WORLD FEDERATION FOR MENTAL HEALTH

The Josiah Macy, Jr., Foundation, of New York, has announced its decision to make a generous contribution toward the budget of the World Federation for Mental Health, which for the first few years is likely to need some £30,000 annually. The donation will be \$15,000 a year for the next three years. For the first year it will be unconditional. For the two later years the grants will be made on condition that the federation raises a sum of at least \$60,000 a year from other sources.

It has also been announced that an anonymous British donor has given £7,500 to be spread over the next three years, to meet the salary of a director of the federation.

## INTERNATIONAL STUDY WEEKS FOR CHILD VICTIMS OF THE WAR

In September, 1945, some 200 specialists from 18 European countries—psychiatrists, educators, psychologists, and jurists—met together, at Zurich. Their object was to formulate a program of mental aid on the basis of recent experience. After ascertaining that practically the same problems presented themselves in every country, the S.E.P.E.G. (*Semaines internationales d'Etudes pour l'Enfance Victime de la Guerre*) at Zurich came to the conclusion, amongst others, that mental aid complements material aid, and that the various specialists should evolve in common plans of action to help children, this help as a rule to be local. The Zurich charter served as a working basis for most of the groups that were formed abroad.

The Don Suisse and, later, the Swiss Aid to Europe generously granted financial aid to the Zurich S.E.P.E.G. and its subsequent activities, amongst them the following:

Several medico-pedagogic training courses were held at Lausanne under the direction of Dr. Lucien Bovet, each comprising from forty to fifty qualified students. A similar course was held in German, at Zurich, directed by Dr. J. Lutz.

Several S.E.P.E.G. meetings were held in France (Grenoble) in Italy, (Milan, Rimini, Florence, Rome), and in Germany. An important S.E.P.E.G. meeting took place last year at Otwock near Warsaw. A special number of the magazine *Sauvegarde* has published the principal scientific lectures and the resolutions.

An action on a larger scale was undertaken this year, to help the children of southern Italy. This meeting assembled chiefly doctors and educators, representatives of governmental and private organizations, with the aim of assisting local initiative.

A collection organized in Switzerland made it possible for five railway-carloads of educational material to be sent and distributed to the most needy schools. This action was amplified by an exhibition of children's books, children's drawings, and the showing of films. A committee of Italian artists and writers was formed with the aim of helping children and of taking an interest in all the cultural problems of the country.

The presence of foreign specialists, visits to institutions, the exchange of ideas and experiences, articles in the local press, all contribute to augment the value of the measures suggested. The elaboration of the program is left to the country in question.

The aim of S.E.P.E.G. is to further everywhere the activities inspired by those in various fields of work who are endeavoring to utilize the discoveries of science in the service of child welfare.

Social and economic science, pedagogy, medicine, psychology, law—all these should contribute to the building of the future societies in which young people may recover their lost places.

In pursuit of its aim, S.E.P.E.G. has assumed certain tasks that have been demanded by certain regions or countries. As already stated, it has received grants from the Swiss Aid to Europe and the Don Suisse. It has become affiliated with the U.I.P.E. (*Union internationale de Protection de l'Enfance*), with the Swiss Aid to Europe, and with the World Federation for Mental Health.

#### U. S. PSYCHIATRIST NAMED HEAD OF WORLD HEALTH ORGANIZATION'S MENTAL-HEALTH GROUP

Dr. William C. Menninger, Secretary of the Menninger Foundation, of Topeka, Kansas, has been elected chairman of the World Health Organization's Expert Committee on Mental Health, which will organize the first international mental-health program, as approved by the second World Health Assembly in Rome in June.

Among the items on the committee's agenda are: World Health Organization collaboration with the United Nations in a study of the causes and prevention of crime and the treatment of offenders; psychiatric examination of offenders prior to sentence; juvenile delinquency; mental-health problems arising in rural districts, in industrial units, and among students; mental-health training for medical and other personnel and public education; mental health and child care; medical statistics and nomenclature.

The committee will also consider further World Health Organization collaboration with the World Federation for Mental Health, which has just concluded its annual meeting in Geneva.

#### INSTITUTE OF PSYCHOSOMATIC AND PSYCHIATRIC RESEARCH AND TRAINING GETS NEW BUILDING

Announcement has been made by Michael Reese Hospital of Chicago, Illinois, that construction has begun on a \$1,850,000 building to house its Institute for Psychosomatic and Psychiatric Research and Training. Funds for the new building were provided by the Jewish Federation of Chicago; by Mr. and Mrs. A. D. Lasker, of New York City; Mr. and Mrs. Leigh Block, of Chicago; and Mr. and Mrs. Sidney Brody, Beverly Hills, California.

The Institute for Psychosomatic and Psychiatric Research and Training has been set up and functioning since 1946, under the direction of Dr. Roy R. Grinker. During this time, while the new structure was being planned, the institute has been without separate building facilities.

The new building is the result of years of study by architects, psychiatrists, and hospital consultants. It is to be a five-story structure with 82 patient beds. The total floor area is 82,000 square feet. There will be radiant heating throughout the patient areas. A tunnel system will connect the institute with the main hospital a block north. Every attempt has been made in the design of the building to eliminate any institutional feeling and to encourage group activities.

"Our general purpose," states Dr. Roy R. Grinker, Director of the Institute, "is to have a facility in which the problem of the emotionally disturbed patient, with or without physical symptoms, can be studied and treated with the concept that his mind and body constitute an inseparable unit which requires the coöperation of many specialists, and that this concept is a central point of teaching not only psychiatrists, but all other medical men. A psychiatric hospital has a community responsibility, and one-third of our beds will be service cases—part pay or no pay. Our research program will be supported by a fund created by the A. D. Lasker family and supplemented by private donors and government subsidies.

"There will be facilities for research, teaching, and care of patients. About 20 per cent of the space has been set aside for research. This includes laboratories, not directly connected with the patient, such as the biochemistry and physiology laboratories, and the research facilities that have to do with patients—electroencephalographic facilities, physiological testing, and large laboratories for psychology.

"One of the prime purposes at the institute will be the teaching of much needed trained personnel: resident physicians training to become psychiatrists, medical students, social workers, nurses, occupational therapists, psychologists, ministers, and internes, residents, and staff doctors in other specialties on the Michael Reese Hospital staff. Large seminar and conference rooms have been provided. There will be an amphitheater seating 125, a library, and nurses' classrooms on each floor.

"Seventy per cent of the space has been devoted to patients. Although the divisions are flexible, this space has been divided into four sections. The psychosomatic section, which has thirty-two beds, will deal with physical disturbances in which a large element of the cause of the disturbance itself is emotional. This includes such conditions as dyspepsia, ulcer, diarrhea, colitis, asthma, headaches, diabetes, arthritis, and so on. Since these are not just pure mental and emotional disorders, but medical problems that confront every doctor daily, the patients on this floor will be cared for comprehensively by both internists and psychiatrists in coöperation. The

chief of this section is Dr. Sidney Portis of the Michael Reese Medical Staff.

"One entire floor will be devoted to the psychiatric section. There we will hospitalize people who are directly emotionally disturbed with anxieties and depressions and who need care outside of their home environment. By setting up such a unit, we will save them from the highly expensive private sanitariums, or for the less well off, from the overcrowded public mental institutions. They will get the best psychiatric care, and all the necessary medical auxiliary services, on the principle that the psychiatric patient should be hospitalized where he can be given such facilities and personnel for thorough study and treatment of body and mind, and where he will find a cheerful and hopeful environment suggestive of all that is familiar in a good hospital atmosphere.

"For a quarter of a century Michael Reese psychiatrists have done pioneering work with children. In one of the wings twelve to eighteen beds will be set aside for the hospitalization of children with behavior problems who need to be away from home. A doctor will be in attendance in this unit all the time. There will be plenty of play and recreation space for children to function in groups.

"There will also be a unit for severely disturbed mental patients, with facilities to handle them without the necessity of state institutional care. The purpose of this unit will be to get the patient into a state of better equilibrium, at which time they can be treated for the causative problem.

"On each floor there will be numerous treatment rooms and offices so that the patient can be interviewed and treated with the utmost privacy.

"On the ground floor, opening directly on a spacious landscaped garden and recreational area, there will be a large occupational-therapy unit for children and adults."

#### NEW INFIRMARY AT CRAIG COLONY

The first building completed under New York State's post-war construction program to increase the facilities of the department of mental hygiene was officially opened on June 9. It is a 200-bed infirmary at Craig Colony, the department's institution for epileptics, located at Sonyea, Livingston County. The new building will not only alleviate overcrowding of Craig Colony generally, Dr. William H. Veeder, Director of Craig Colony, pointed out, but will permit more efficient grouping of patients according to age.

Craig Colony now houses approximately 2,224 epileptic patients, providing full medical care, including special treatment for con-

vulsive disorders. Children of school age receive instruction in academic subjects so far as their capacities for learning permit, and occupational therapy is prescribed for patients of all ages. Not only age, but mental and physical capabilities are considered in grouping patients, and a program of exercise, social contact, and intellectual stimulation is maintained. In addition to the larger institution buildings, cottages are provided where patients may live under supervision in fairly normal surroundings.

#### RICHARD H. HUTCHINGS MEMORIAL AWARD

A memorial award of \$100.00 for an outstanding contribution to psychiatry from a public mental institution was recently announced by Dr. Harry A. Steckel, former Director of Syracuse Psychopathic Hospital, and head of a committee to honor the late Dr. Richard H. Hutchings. The award, in memory of Dr. Hutchings, who spent his life in the state-hospital field, is from an anonymous donor, Dr. Steckel said, and is presented through Dr. C. Charles Burlingame, Psychiatrist-in-Chief of the Institute of Living, Hartford, Connecticut, who is also a member of the Hutchings memorial committee. The award, Dr. Steckel announced, is without restriction as to type of professional achievement and may be made by the memorial committee at a time within its discretion. Scientific articles, reports, or nominations for the award may be submitted to Dr. Steckel or to Dr. Newton Bigelow, Director of Marcy State Hospital and secretary-treasurer of the committee.

The memorial committee, elected by friends and former colleagues of Dr. Hutchings who have set up a fund in his honor, has the primary purpose of sponsoring a series of annual scientific lectures in memory of Dr. Hutchings, who was a clinician, administrator, and teacher.

Dr. Hutchings, who died in October, 1947, was head of St. Lawrence State Hospital and later of Utica State Hospital for many years, and for many years taught psychiatry at Syracuse University College of Medicine.

The first of the memorial lectures is expected to be given this fall, probably at the Syracuse Medical College.

#### SOCIETY FOR CLINICAL AND EXPERIMENTAL HYPNOSIS

A society to be known as The Society for Clinical and Experimental Hypnosis has recently been organized for the purpose of stimulating research and publications in the field of hypnosis. The officers are: Chairman, Jerome M. Schneck, Department of Psychiatry, Long Island College of Medicine; Milton V. Kline, psy-

chologist, Westchester County Department of Health; Hugo G. Beigel, Department of Psychology, Long Island University; and Henry Guze, Department of Animal Behavior, American Museum of Natural History. The executive secretary is Mrs. Shirley R. Schneck.

The society is planning a yearbook and any one interested in contributing a paper is invited to send it to Dr. Hugo G. Beigel, Department of Psychology, Long Island University, 380 Pearl Street, Brooklyn 1, New York.

#### THE MENNINGER FOUNDATION SCHOOL FOR PSYCHIATRIC AIDES

For the first time in history, basic psychiatric education is to be offered to mental-hospital attendants in a psychodynamically oriented training school, to start in Topeka, Kansas.

The program will be a school for psychiatric-aide training operated in the facilities of the Topeka State Hospital and the psychiatric hospitals of the Menninger Clinic, with supervision and teaching faculty provided by the Menninger Foundation. The Rockefeller Foundation, of New York, has contributed \$70,500.00 to finance the school. These funds are in the form of a grant just awarded to the Menninger Foundation.

The new school will be one of the training programs in the foundation's department of education, under the general direction of Dr. Karl Menninger. Instructors will be psychiatrists, psychiatric social workers, clinical psychologists, and psychiatric nurses from the staffs of the Menninger Clinic, and from the staff of the Topeka State Hospital as soon as enough adequately trained personnel can be employed in this institution.

Dr. Bernard H. Hall, member of the foundation's professional staff, will direct the new educational program. Dr. Hall has worked with the project since the idea first originated among a group of psychiatric aides at Winter Veterans Administration Hospital, and served as chairman of a group that made a comprehensive study of the situation while he was a resident at Winter and a fellow in the school of psychiatry.

Other staff members on the aid project will be Miss Esther Lazaro, R.N., of the staff of the Menninger Clinic, who will be associate director; Ream A. Lazaro, who will serve as administrative assistant; and Mrs. Paul E. Pollard, secretary.

The school is being established for a three-year period, under the terms of the Rockefeller Foundation grant. Courses will run for twelve months, divided into two six-months semesters. Training will be given at the Topeka State Hospital with a six-weeks rotation

period for each student at the psychiatric hospitals of the Menninger Clinic.

"Students will not pay fees for the education they receive in this pioneering school, but must meet certain qualifications before they can be appointed," Dr. Hall said. Candidates should have at least a high-school education, be between eighteen and thirty-five years of age, and be free to accept employment at the Topeka State Hospital as attendants.

"In addition," Dr. Hall stated, "students will be selected on the basis of personality adjustment and an aptitude for leadership. As admissions will have to be limited to a group of twenty-five students each six months, we expect to screen candidates carefully, and select those who will be able to act as leaders after they have received the training here."

Classes for the new program will begin October 1, 1949; April 1, 1950; April 1, 1951; October 1, 1951; and April 1, 1952. Applications for enrollment may be directed to Dr. Hall at the Menninger Foundation.

The curriculum for the new school includes a wide variety of courses designed to provide a student psychiatric aide with an understanding of psychiatric symptoms, their origin, and treatment. The proper care of the mentally ill will be emphasized.

Concurrently with the new school, and with support from the Rockefeller Foundation grant, the Menninger Foundation will initiate and carry on a new research project, concerned with developing methods for selecting persons best qualified for this kind of work.

#### HOSPITAL HELPS PARENTS RAISE HAPPIER CHILDREN

Two public courses in child management, led by authorities in the field of psychiatry, are being offered this fall by the Presbyterian Hospital in Philadelphia. Designed to give parents a better understanding of the emotional needs of their children, the courses will present information of practical value in raising better-adjusted, happier youngsters.

Planned for eight Thursday evenings, beginning September 29th, is the second Parent Guidance Institute series of lectures on basic parent-child relationships. Among those scheduled to speak are Dr. Edward A. Strecker, Chairman of the Department of Psychiatry, University of Pennsylvania's School of Medicine; Dr. Charles Burlingame, Psychiatrist-in-Chief, Institute of Living, Hartford Connecticut; Dr. Eleanor Steele, assistant professor of psychiatry, Temple University Medical School, Philadelphia; and Dr. Samuel B. Hadden, Chief of Presbyterian Hospital's Neuropsychiatric Department.

The second course consists of child-management discussion groups, each group limited to ten parents. Group members meet at the hospital for ten informal discussions of child-management problems under the leadership of psychiatrists from Presbyterian Hospital's medical staff. Afternoon and evening groups meet weekly, beginning with the final week in September. A nominal charge is made for this service.

Tickets for the lectures and reservations for the discussion groups are being handled by the social-service department of the hospital.

#### WALTER E. FERNALD STATE SCHOOL OFFERS TRAINING IN PSYCHIATRY

The United States Public Health Service, under the National Mental Health Act, has approved a grant for a trainee in psychiatry at the Walter E. Fernald State School, situated eight miles from Boston. The stipend is level 5, or \$3,000.00 per year. However, candidates at lower levels may be considered and the amount of the stipend adjusted to the level of the candidate's training. Training will be offered in mental deficiency, child psychiatry, and related psychiatric and neurological problems through supervised experience in the outpatient, inpatient, research-laboratory, psychological, educational, and social-service departments, as well as through participation in staff meetings, and seminars in basic psychiatry and neurology and child psychiatry.

Applications, including the applicant's qualifications, or requests for further information should be sent to Dr. Malcolm J. Farrell, Superintendent, Walter E. Fernald State School, Waverley 78, Massachusetts.

#### ARMY COURSE FOR PSYCHIATRIC SOCIAL WORKERS

A new army training program for psychiatric social workers has been announced by the army medical department. Male graduate students of social case-work who desire a career with the regular army medical-service corps and who are enrolled in graduate schools of social work approved by the secretary of the army are invited to apply.

Commissions as second lieutenants in the Medical Service Corps Reserve will be tendered to selected students during the fiscal years 1950 and 1951. Under this program students who are commissioned will be permitted to continue in their respective schools as officers on active duty, with full pay and allowances, until completion of academic requirements for the Master of Social Work degree (or its equivalent), with a social-case-work major. Upon receipt of the professional degree, student officers will serve for two years in the army.

Candidates for this program must be male citizens of the United States, able to meet the physical standards prescribed for the regular army, not under twenty-one nor over twenty-nine and one-half years of age on the date of application. Each candidate must have successfully completed one full academic graduate year of training in social case-work in a school of social work approved by the department of the army.

Applications may be obtained by writing to The Surgeon General, Department of the Army, Main Navy Building, Washington 25, D. C., Attn: Chief, Personnel Division. Completed applications must be submitted prior to June 1, 1950, for fiscal year 1951.

#### GIFT OF \$2,000,000 TO YALE FOR PSYCHIATRIC WORK WITH STUDENTS

A gift of \$2,000,000 to Yale University to expand its work in psychiatric guidance of students has been made by the Old Dominion Foundation, of Washington, D. C.

Yale's present program of psychological and psychiatric assistance and guidance to students is under the supervision of Dr. Clements C. Fry, Head of the Division of Psychiatry and Mental Hygiene of the Yale Department of Health. Dr. Fry will be in charge also of the expanded program.

In discussing his division, Dr. Fry emphasized that "the ultimate objective, from the research point of view, is to establish here at Yale a center for the thorough study of the young adult within a psychiatric, psychological, and sociological framework.

"A nucleus for such a center already exists," he declared. "With the assurance of adequate permanent funds, this center can now be built up along the desired lines."

As planned by Dr. Fry, the functions of his division will be expanded in several directions: clinical, research, training, education, and publication.

#### PSYCHIATRIC FELLOWSHIP AT CEDARS OF LEBANON HOSPITAL

A twelve-month fellowship has been established in the Psychiatric Department of the Cedars of Lebanon Hospital, Los Angeles, California. This will include practical experience in psychotherapy with ambulatory patients and in the diagnosis and treatment of psychosomatic disorders of patients hospitalized on the clinic medical and surgical inpatient service, as well as in other diagnostic and psychiatric problems that arise in a general hospital with a large outpatient department. The fellowship carries no stipend, but room and board will be provided.

Interested physicians should apply to Dr. Eugene Ziskind, Director,

Psychiatric Clinic, Cedars of Lebanon Hospital, 1306 N. Berendo St., Los Angeles 27, California.

#### NEWS OF MENTAL-HYGIENE SOCIETIES

*Compiled by*

MARJORIE H. FRANK

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The National Committee for Mental Hygiene*

#### *California*

The Mental Health Society of Northern California reports that analyses of the many bills pertaining to mental health were compiled during the sessions of the state legislature, and a four-page special legislative *Newsletter* was issued to the entire membership. This included a list of legislators by counties, and the names of the chairmen of the various committees handling mental-health bills.

An exhibit of mental-hygiene literature and posters was arranged for the three-day meeting of the California Conference of Health, Physical Education, and Recreation held for teachers in San Francisco. Two thousand teachers attended the sessions.

The society also had an exhibit at the state fair in Sacramento, September 1 to 11. The theme of this exhibit was "The Child of To-day Is the Citizen of To-morrow," and the exhibit included panels presenting the needs of a child from infancy to adulthood, a display of books and pamphlets, and leaflet material for distribution.

The Southern California Society for Mental Hygiene has planned an expansion program to develop chapters in many Southern California cities, in addition to those already existing in Los Angeles, Santa Barbara, and Riverside. To facilitate this, an assistant director has been appointed on a temporary basis as part of the program to demonstrate the possibilities for growth of Southern California's mental-hygiene movement. Previous requests for help with mental-health programs in the cities near Los Angeles have indicated that support is now possible to advance programs of research, prevention, and treatment.

In a summary of its recent activities, the society states that mental health in Southern California took a long stride forward in May, 1949, when the society issued a charter to its members in Riverside. The Riverside County Chapter opened its activities in July with a lecture by Dr. James L. Hymes, author and expert on children, on "Living with Young Children To-day." Dr. Hymes had previously spoken to members in Los Angeles.

"Adolescence as a Turning Point," "Problem: Adolescent or Parent?" and "Mental Hygiene for the Adolescent," were the topics

of the Spring Seminar on Adolescence presented by the society, in April. Dr. Herbert Kupper, psychiatrist, was the speaker. Five hundred parents and teachers attended.

#### *Connecticut*

The Connecticut Society for Mental Hygiene reports that its energies have been centered to some extent upon activating interest in the proposed Child Study and Treatment Home and in a bill for its support which was up before the Connecticut General Assembly.

In exploiting all the possible educational angles of *The Snake Pit*, the Connecticut Society worked with the public-relations men of 20th Century Fox in New York and Connecticut and with local theater managers. There was a preview in New Haven and a special showing for the legislators in Hartford; several thousand leaflets were distributed in the theater, and support was stimulated in local communities where there was opposition to the picture. The Junior League put on a special showing of the film in New Haven with explanations, and questions from the audience answered by Dr. John Dollard, of the Yale Department of Psychology, and Dr. F. C. Redlich, of the Department of Psychiatry. The society states that this showing, after the amusement tax was paid, netted a profit of \$423.94—as well as being of great value as an educational project.

Through its medical advisory committee, the society worked with the state department of health in planning expenditure of National Mental Health Act Funds allocated to Connecticut. Funds for two projects were made available:

1. A seminar in group dynamics for a small number of community leaders, brought together by Miss Frances Hartshorne, Executive Secretary of the Connecticut Society. In this seminar interrelationships were observed at the moment when they took place—a new method of group learning which considers motivation at the time when group behavior is actually happening. The group met eight times, with Dr. Helen Gilmore and Dr. Edward Stainbrook, both of the Yale Department of Psychiatry, conducting the seminar. Reports from the participants indicate that it was tremendously interesting and valuable as education in the field of leadership, showing, as it did, what behavior means at the time when it is being exhibited within the group.

2. The second project involved research on public opinions about psychiatry and mental health. A program of lectures was undertaken, sponsored by the Connecticut Society for Mental Hygiene and the Yale Department of Psychiatry, which included the administration of a specially designed questionnaire and sentence-comple-

tion test, followed by a discussion of the questions raised. This was carried out by Dr. F. C. Redlich and Dr. Robert A. Kimmich, of the Yale Department of Psychiatry, and Miss Frances Hartshorne. National Mental Health Act Funds are to be used to analyze the data, both for Yale University and for The Connecticut Society for Mental Hygiene.

The society's Forty-first Annual Meeting was held on June 9 at the Hotel Elton, Waterbury, Connecticut. One hundred and twenty-five members and friends attended the luncheon and the panel discussion on "A Community Mental Health Program," led by Dr. Edward Stainbrook; Miss Marion F. McBee, of The National Committee for Mental Hygiene; Mr. William H. Savin, of the Massachusetts Society for Mental Hygiene; and Mrs. Rodney Chase, President of the Waterbury Society.

### *Hawaii*

A letter received from the Mental Hygiene Society of Hawaii reports the following activities:

"In addition to a successful repeat of Mental Health Week, there have been two developments that will, perhaps, be of interest to The National Committee for Mental Hygiene.

"A local branch of the Mental Hygiene Society of Hawaii was formed on the Island of Kauai during Mental Health Week. The constitution was adopted at a business meeting held on Tuesday, April 26. Father Joseph Robeck was elected president of the new organization. It is already an active unit, receiving stimulating leadership from Mrs. Mabel C. McConnell, psychiatric social worker with the board of health on the Island of Kauai. A local chapter presents its geographic difficulties here in the territory, as we cannot get into our car and drive to meetings, but must fly to them.

"The other development was a postgraduate institute in pediatrics and child psychiatry held in Honolulu during May. This institute was partially financed by funds received under the Mental Health Act. In addition to the institute, the guest lecturers participated in the annual meeting of the territorial medical society and a membership meeting of the mental-hygiene society. The attendance at the meetings was varied, including physicians, social workers, nurses, teachers, ministers, judges, and parents. There was a total registration of 287.

"As for the particular work of the society, the board of directors has just voted for the formation of two new committees—one of volunteer workers for the territorial mental hospital and the other an advisory and coordinating committee for the use of the public and private agencies that have or plan to have mental-hygiene programs. This committee plans to help agencies in the use of present facilities, so that they may be utilized to the maximum, to prevent duplication of services and to be a sounding board for future plans and present dissatisfactions."

*Illinois*

The following interesting items were obtained from a newsletter issued by the Illinois Society for Mental Hygiene:

A Nursing Education Institute was held in Springfield on June 3 and 4, sponsored by the Illinois Department of Public Health, the Illinois Department of Registration and Education, and the Illinois Society for Mental Hygiene. Funds were made available by the department of health under the National Mental Health Act. While not listed formally as a sponsor, the Illinois Department of Public Welfare was in effect more than a sponsor, since most of the speakers, almost half of the planning committee, and all of the discussion leaders came from that department. This institute was a real success, to judge from the comments of those who attended, as every one of the speakers caught the spirit of the project and geared their presentations to the needs of the audience.

The society is very much pleased with reports of its chapter's activities. Mention was made of the excellent leadership and program of the Rockford, Peoria, and Springfield chapters.

The society reports that Mr. Lewis Leavitt, a member of the society and a student at Wright Junior College, is a good example of what lay members can do to promote mental-hygiene education. Mr. Leavitt became interested in mental hygiene while at Wright, and developed a one-man crusade. A report of his activities indicates that he wrote three papers, and six reports and gave sixteen lectures. Many of the lectures were accompanied by films. In this connection he worked out a rating scale of audience reaction to films.

A copy of Mr. Leavitt's report is available at the headquarters of the Illinois society for scrutiny, and the society will be happy to assist any one who is interested in doing something similar.

*Indiana*

The Indiana Mental Hygiene Society has informed us that although it was founded only eight months ago, it has outgrown its original temporary quarters and has gained a full-time executive director, Mr. Walter Argow. Assisting Mr. Argow on the executive staff are Mrs. Letta I. Shonle, who continues her responsibility for the community-organization activity, and Mrs. Beulah Wacker, the office manager.

*Kansas*

Monthly bulletins received from the Kansas Society for Mental Hygiene show that the 1949 state legislature met in most respects the goals of the legislative platform of the Kansas Society for Mental

Hygiene. That platform had called for "sufficient appropriations to provide staff, buildings, and equipment for the state mental hospitals in accordance with the recommendations of the Governor's Advisory Committee and to follow through on the recommendations made in the study of psychiatric facilities in Kansas made by the U. S. Public Health Service in November, 1946."

By appropriations under House Bills 359 and 429, the 1949 legislature allotted money for marked improvements in all state institutions, to begin providing adequate treatment in the state hospitals for the mentally ill. It also provided that Topeka State Hospital become a training center for psychiatric personnel.

Deficiency appropriations were passed and appropriations for the coming biennium were greater than ever before, to provide for higher salaries and better maintenance.

The state department of social welfare was reorganized so that mental hospitals are now under a bipartisan board with overlapping terms of office. (Item 7 of the society's platform.) The board of welfare will now consist of three non-salaried members who will oversee the activity of a paid state director. Under this director will be a state supervisor of institutional management, who will have direct charge of the state mental hospitals. His actions will be subject to advisement of a new five-member advisory commission on institutional management. This commission is to be composed of three physicians, one of whom will be a psychiatrist, and two laymen.

The training program at Topeka State Hospital is designed to draw residents, internes, and student nurses, aides, social workers, and therapists to the hospital. An immediate goal is to get the hospital approved by the American Psychiatric Association. The long-run aim is to provide adequately trained staffs for all the state hospitals.

Money was raised to extend the service of the psychiatric receiving ward at the University of Kansas Medical Center and to provide a new building to house that service, as well as additional facilities for the training of more doctors. This extends preventive services hand in hand with treatment of the mentally ill.

This society reports the organization of two new local societies, one in Sedgwick County and one in Wyandotte County.

### *Maryland*

According to present plans for its 1950 program, the Mental Hygiene Society of Maryland will be focusing on mental hospitals, community clinics, and the feeble-minded. The plans call for:

1. Development of a broad program of volunteer service to the mental hospitals, with emphasis on screening and training.

2. The promotion of mental-hygiene clinics under state, city, and private agencies.
3. The development of a state-wide program for the feeble-minded, both community and institutional, starting with a series of discussions on the problems in this field.
4. The development of a legislative program to implement the first three projects and the organization of broad community support.

The society expects to promote a large part of its program through the monthly publication of its bulletin, *Spotlight on Mental Health*, and has the full coöperation of state-hospital administrative staffs, as well as of the psychiatrists in private practice in Baltimore.

In an exchange of correspondence between Governor William Preston Lane and Mrs. Ruth Murray, Chairman of the Mental Hygiene Committee of the Baltimore Federation of Labor, the governor agreed that representatives of the Mental Hygiene Society of Maryland and of organized labor should be appointed to the board of review.

The board of review is a body set up by law at the last session of the legislature to visit the mental institutions of the state twice yearly and submit an annual report to the governor on conditions and suggestions for reform. Appointed by the governor with the consent of the senate, it is to consist of representatives of the senate and of the house of delegates, two psychiatrists, one physician outside of psychiatry, one psychologist, one educator, one psychiatric social worker, and three "other persons of recognized ability."

#### Michigan

As a member agency of the United Health and Welfare Fund of Michigan, the Michigan Society for Mental Hygiene is one of twenty-one state and national organizations that participated in the 1949 campaign. In coöperation with its ten active chapters and the Michigan Department of Mental Health, it has made available fourteen sets of the radio programs, *The Inquiring Parent*, which will be used by radio stations starting in September. Its *Mental Hygiene Bulletin*, which is published quarterly, gives an excellent picture of the mental-hygiene needs and resources in Michigan as well as being an excellent means of education, with its interesting articles by well-known authorities.

Two new chapters of the society have recently been organized in Ingham and Wayne counties.

The Thirteenth Annual State Conference of the Michigan Society for Mental Hygiene was held in Detroit on October 10, 11, and 12.

Twenty-two other Detroit and Michigan service and professional organizations were co-sponsors of the conference.

### *Minnesota*

The Minnesota Mental Hygiene Society, in its August, 1949, bulletin, reports:

"As a result of a series of meetings, the Educational Committee is establishing a program for the promotion of better mental health through education. Because therapeutic aspects have been given considerable emphasis, it was decided that the Minnesota Mental Hygiene Society, through its educational program, should concentrate its efforts to aid the move toward better understanding of mental health. It plans on stimulating interested community organizations to foster such understanding among their memberships. In its deliberately slow approach to this ambitious program it will probably, at first, confine its efforts to four groups—parent-teacher associations, churches, labor, and industry—and institute only limited programs in these four fields, so as to prove the program by using it for demonstration purposes.

"Recognizing that problems of urban and suburban communities differ, a survey was made in Hennepin County, and one is in progress in Nobles County. It is the intention of the committee to institute programs in these two counties, based on the needs and facilities revealed by the survey.

"Establishment of the first mental-hygiene clinic for children in Minneapolis was made possible by the coöperative efforts of several local groups. The Minnesota Mental Hygiene Society helped achieve this goal by coördinating the efforts of the Washburn Foundation, the University of Minnesota, and St. Barnabas Hospital. Trustees of the Washburn Foundation, headed by its president, Mrs. Richard M. Hersey, petitioned the court for permission to change its program of foster-home care for emotionally disturbed children to one that provides an out-patient mental-hygiene service for children in connection with a private hospital. Verbal court approval was granted simultaneously with action by the University of Minnesota regents, authorizing an affiliation in the enterprise between Washburn Home, the University Medical School, and St. Barnabas Hospital. Meetings between these various groups were initiated by members of the staff of the Minnesota Mental Hygiene Society. Further help was offered by the Stevens Avenue Home, which contributed a substantial sum for the clinic, and from the Minneapolis Woman's Club, which pledged \$2,000 for remodeling costs at St. Barnabas. The Woman's Club, to raise funds for their pledge, sponsored 'A Day in the Country' at the John S. Pillsbury estate, Brackett's Point, Lake Minnetonka. A record crowd turned out to support the project, giving further evidence of the tremendous popular interest that exists in any tangible program concerning mental health. The interesting thing about the Woman's Club activity is that they committed themselves for \$2,000 and yet 'A Day in the Country' netted them \$5,600.

"The Volunteer Service Bureau of the Minnesota Mental Hygiene Society is well organized. One of their outstanding accomplishments is the organizing of the Federated Church Women for volunteer service

at the Anoka State Hospital. Dr. Edmund W. Miller, superintendent of that hospital, feels that the volunteer work done by the Federated Church Women is a very definite help. Eighteen churches are represented in the present volunteer group.

"Over 200 pamphlets have been reviewed and catalogued by our efficient library committee. New books on mental hygiene are being made available through funds recently given as a memorial for Miss Bertha Ferguson, former president and member of the society.

"To tell the story of mental health in an eye-catching manner, an effective display of our literature has been shown at more than 50 meetings since January 1st."

"The Minnesota Mental Hygiene Society held a Membership Meeting on June 1, 1949, at the University of Minnesota. Dr. Alan Challman spoke before approximately 400 people on the subject of 'Preventive Psychiatry.'"

### *Missouri*

The Missouri Association for Mental Hygiene and the Kansas City Mental Hygiene Society announce that "the organization of a mental-health center for Greater Kansas City, in which existing services in psychological medicine would be coördinated under central professional guidance and financing, has reached the state of selecting the board of directors who will carry the plan to fruition. This board will consist of professional and lay men and women.

"The organization is being based upon recommendations of Dr. Jules V. Coleman, Colorado psychiatrist, who is consultant to the Kansas City Association of Trusts and Foundations. . . .

"He made a survey of Kansas City's psychiatric facilities and agencies last summer, for the association, which was made public in the winter. The key recommendation in his report was that the Kansas City Mental Health Center be organized with existing agencies included in it, for all types of preventive and therapeutic services, adult and child-guidance work, community health, and education and research.

"The proposed center would go beyond the scope of anything of its kind now existing in the country, in that it would include education, training, and research on a basis of importance equal to care, treatment, public mental hygiene, and guidance services.

"The importance of education and research can hardly be overestimated. It is the same problem here that it is everywhere except in a few veterans hospitals. Not only is there an acute shortage of professional personnel; there is no place in the country where education and research are geared to community service as distinguished from private and hospital practice.

"It means that the proposed center would be tied in with the University of Kansas Medical Center, and probably the University of Kansas City. It would, beginning with the present personnel working in the various agencies to be included, expand its community services while at the same time expanding its personnel by training.

"The existing agencies whose work would be coördinated are the child-guidance clinic, the juvenile-court psychiatric services, the Alfred Benjamin Dispensary, the Kansas City Family Service, the general-

hospital neuropsychiatric clinic, the mental-hygiene society, and, of course, the universities.

"It is not contemplated that the mental-health center will supersede any of the existing agencies, but, rather, that they will continue their regular activities under their own power, so to speak, with new services to be set up by the new center and added to the services of the agencies, and their functions will be all coördinated.

"Preventive mental hygiene would be the main field of community activity."

### *New Jersey*

There has been increasing interest in local mental-hygiene societies in New Jersey during the last year, related in some measure to the setting up of the new Mental Hygiene Society of New Jersey. Those local societies already well established—in Union County, in Atlantic County, and in the Paterson area—have further developed their plans.

Among the activities in the Union County Society were panel discussions, open-house days in the guidance clinic, the showing of American Theatre Wing productions, and seminars for selected groups. Wide use of material was made for Mental Health Week, and publicity committees printed and distributed educational pamphlets. An active membership of over 200 maintains the mental-hygiene clinic where psychiatric service for both adults and children is provided.

The Atlantic County Society already numbers over 300, and has conducted an educational program, including an institute, a public-lecture series featuring prominent psychiatrists, a well-planned entertainment program in the county mental hospital, and meetings with groups of county police.

The Paterson Mental Hygiene Society, with a paying membership of 327, held three large meetings, with educational programs featuring speakers, theater groups, and film discussions. It made wide use of publicity during Mental Health Week. It has made a significant contribution in stimulating the establishment of a community clinic, "The Paterson Mental Health Center," which is governed by a committee appointed by the president of the mental-hygiene society.

Monmouth County recently set up its own mental-hygiene society, with an active membership. Committee objectives and participation are now being worked out. In both the Essex County group and the Somerset County group large initial meetings have been held, following which committees have gone to work. In Essex, fact-finding committees are at work over the summer.

In Sussex, the County Welfare League has appointed a committee to plan for organizing a society, while in Warren County and in Morris County, the Councils of Social Agencies have themselves planned to undertake this project. There is considerable interest

in Burlington and in Camden Counties, as well as in Gloucester County, where two local groups exist—The Citizens Mental Health group, sponsored by the Woman's Club of Woodbury, and the Pitman local group.

#### *North Carolina*

The North Carolina Mental Hygiene Society has appointed a committee to work in coöperation with the Medical Care Commission in relation to all hospitals that are being built through state and federal funds.

#### *Ohio*

The Ohio Mental Hygiene Association has been very active in the legislative field. Mrs. Wells, the society's executive secretary, writes:

"We have been successful in getting the two bills in which we were most interested passed and they are now awaiting the signature of the governor. These bills simplify admittance to state hospitals and also provide for a rotary fund to be established from increased fees of mental patients. At the present time, the maximum weekly fee is \$5.50 per patient and this bill will allow the state hospitals to charge what the patient can afford, the surplus over the \$5.50 going into a fund for prevention, education, community clinics, research.

"The Division of Mental Hygiene feels that this bill will supply enough funds to expand our community-clinic program here in Ohio.

"At the present time, the state association has twenty county societies in process of organization and affiliation. We are continuing our Crusade for Happiness, doing periodic mailings of 100,000 monthly. The first phase of the campaign we feel was successful both financially and educationally as we are now recognized as an effective organization in the state and are operating with some degree of financial security."

The Allen County Mental Hygiene Association was reactivated in 1948 after inactivity during the war years. It adopted a new constitution, affiliating with the Ohio Mental Hygiene Association, with joint memberships. The association adopted as its major project the sponsoring of a mental-hygiene clinic.

Community effort is being directed toward the discovery of emotionally disturbed children through school channels. Although facilities are inadequate to deal with the whole problem, a beginning has been made.

It is probable that the unit will be taken over as a part of the program of the Division of Mental Hygiene of the Ohio State Department of Public Welfare and its facilities expanded in the near future.

The Montgomery County Mental Hygiene Association reports the progress and activity of its committees on alcoholism, legislation, religion and mental health, speakers bureau, publicity, membership,

human relations in schools, and psychiatric training for student nurses. The monthly newsletter was sent to a mailing list of 1,100 people.

The executive secretary gave 28 talks in three months to an audience of nearly 4,000 listeners. The groups reached included parent-teacher associations, churches, schools, service clubs, women's clubs, and professional groups. A large quantity of a great variety of literature on mental hygiene was distributed, and there was also participation in discussions dealing with the community problem of mentally ill transients, vocational rehabilitation of the convalescent mentally ill, and chronic alcoholism. About ten advanced students in psychology at the University of Dayton were assisted with their term papers on subjects dealing with mental hygiene.

Plans are being made for this society's annual mental-hygiene institute which will take place November 3. Special training conferences for special groups are also being held this year. The society is stimulating the interest of the public to attend the state-hospital summer training course since these lectures are open to the public. Usually from five to twenty visitors have listened in on each of these lectures.

Mrs. Herbst, Secretary of the Mental Hygiene Society of Stark County, reports on the progress of this society which is just about a year old. The society has an active publicity and education committee and as a result of the active organization of laymen interested in better community mental hygiene, the society claims partial responsibility for the establishment of the Stark County Guidance Center.

#### *Texas*

The Texas Society for Mental Hygiene is very much pleased that its major accomplishment of the year has been realized in the passage by the state legislature of a resolution to amend the state constitution to permit the legislature to provide for trials in lunacy cases without a jury. This amendment will be submitted to the people of Texas on November 8, and in the interim the local and state societies' efforts will be directed toward an educational campaign for favorable vote.

Mental Health in Education is the state-wide project adopted at the last annual conference of the Texas Society for Mental Hygiene, and no doubt it will absorb the attention and energies of the local mental-hygiene societies and other interested groups for a number of years. The executive committee has approved a general outline of services to meet the obvious need for effective public relations to interpret the principles of mental hygiene as related to a broader understanding of the problems of children. An advisory committee

will select teams of consultants who will accept invitations in a limited number of communities to help schools develop programs of in-service training for teachers, counseling, visiting-teacher work, and other related services. These teams will be composed of representatives of the various disciplines who will be selected on the basis of the local problems to be studied.

The University of Texas Mental Hygiene Society (a student group) has sponsored a state-wide essay contest among undergraduates in Texas colleges. The first prize, \$50.00, donated by Dr. Paul White, of the University of Texas Health Service, was awarded to James O. Whitaker, of Texas Christian University. His topic was "Religion's Rôle in Mental Health." The second prize, \$15.00, donated by Mrs. Joe Wessendorf, of Richmond, was given to Myverne L. Flatt, of Southwest Texas State Teachers College in San Marcos, who wrote on "Security and Sanity." The third prize, \$10.00, donated by Hogg Foundation, was won by Mrs. Sarah R. Farnsworth, of Trinity University in San Antonio; her topic: "Are We Getting Too Big for Our Britches?" Another third prize, also given by the Hogg Foundation, went to W. C. Garner, Jr., of Hardin-Simmons University at Abilene, for his essay on "The Need of Mental Hygiene."

#### *Wisconsin*

Mr. Oeland, Executive Secretary of the Citizens' Public Welfare Association, reports that the bill to reorganize the department of public welfare has passed both houses by overwhelming majorities and that great help was given to the legislative program of the association by Mr. Roy Matson, Editor of the *Wisconsin State Journal*, through his sympathetic and understanding support.

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EVA R. HAWKINS

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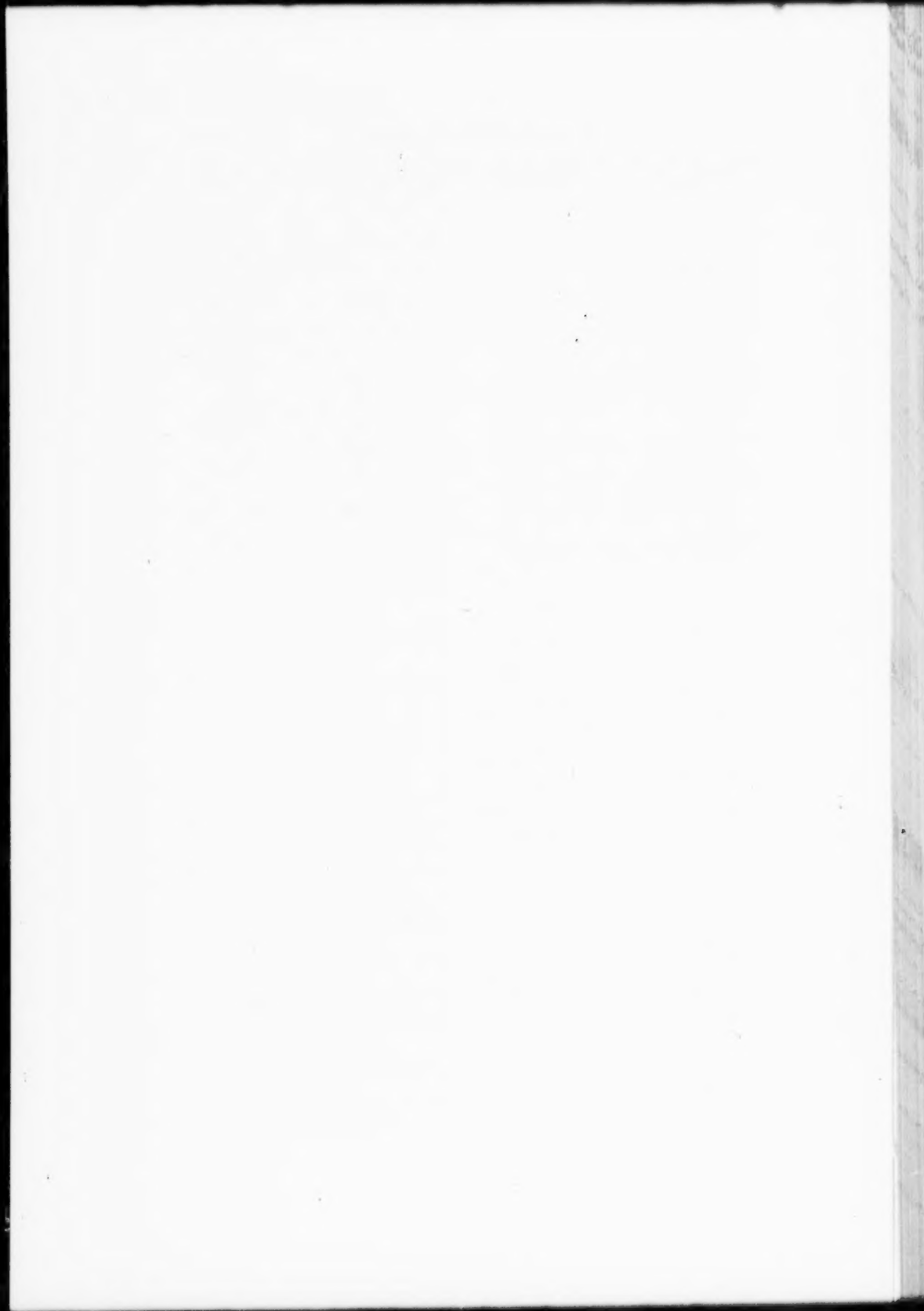
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## Objectives

The National Committee for Mental Hygiene is a voluntary organization working for the promotion of mental health; for the prevention of mental and nervous disorders; for the improved care and treatment of the mentally ill; for the special training and supervision of the mentally deficient; and for the promotion of research.

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